Barcode/Z #:

Patient Information Form

Name:_____ **Today's Date:**_____

Please complete the Patient Information Form and the Patient Intake Questionnaire. Thank You.

Patient Information:

Full Name:_____ Date of Birth:____/____/____
Address:_____ Social Sec #:____-____-____
City:_____ Home Phone: _____
State:_____ Zip:_____ Cell Phone: _____
Email Address: _____
Employer:_____ Work Phone: _____
Emergency Contact:_____ Phone #: _____

Spouse / Parent / Guardian Information:

Full Name:_____ Date of Birth:____/____/____
Address:_____ Social Sec #:____-____-____
City:_____ Home Phone: _____
State:_____ Zip:_____ Cell Phone: _____
Email Address: _____
Employer:_____ Work Phone: _____

Insurance and Primary Care Physician (PCP) Information:

Company:_____ Member/Acct#:_____
Employer:_____ Group #:_____
Member / Policyholder's Name: _____

PCP Name:_____ Phone #: _____
City:_____ State: _____

Please sign this form, and move on to the Patient Intake Questionnaire.

_____
(Your Signature) (Date)

Patient Intake Questionnaire

Barcode/Z #:

Name:_____ **Today's Date:** _____

Reason For Visit:

❑ Pain Symptoms ❑ Wellness Visit ❑ Auto Accident
❑ Work Related Injury ❑ Sports Injury ❑ Other Injury

Date of Injury: _____

❑ **Auto Accident:**

❑ Driver ❑ Passenger, Front ❑ Passenger, Rear ❑ Pedestrian

Were You Wearing Seat Belt? ❑Yes ❑No
Is there a Police Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No
Did You Receive Aid at Scene? ❑Yes ❑No
Were You Taken to Hospital? ❑Yes ❑No

Type of Car?_____ Year? _____ Was the Car Driveable? ❑Yes ❑No

Did You Hit? ❑ Air Bag ❑ Steering Wheel ❑ Side Door ❑ Dashboard ❑ Windshield

Describe the Accident: _____

_____

_____

❑ **Work Related Injury:**

Job Title:_____ Company:_____ How long? _____

Describe Your Normal Work Activities: _____

Did You File a Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No
Were You Taken to Hospital? ❑Yes ❑No

Explain in Detail What Caused the Injury: _____

_____

_____

❑ **Sports or Other Injury:**

Explain in Detail What Caused the Injury: _____

_____

_____

Where Did the Injury Occur? _____

Did You File a Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No
Were You Taken to Hospital? ❑Yes ❑No

Primary Symptoms: (Check all that apply)

❑ Headache	❑ Migraines	❑ Neck Pain	❑ Neck Stiffness	❑ Shoulder Pain
❑ Arm Pain	❑ Low Back Pain	❑ Hip Pain	❑ Leg Pain	❑ Back Pain
❑ Soreness	❑ Discomfort	❑ Numbness	❑ Tingling	❑ Dizziness
❑ Fatigue	❑ Weakness	❑ Memory Loss	❑ Hearing Loss	❑ Depressed
❑ Elbow Pain	❑ Knee Pain	❑ Fever	❑ Sweating	❑ Sleep Problems

Other: _____

Additional Symptoms: _____

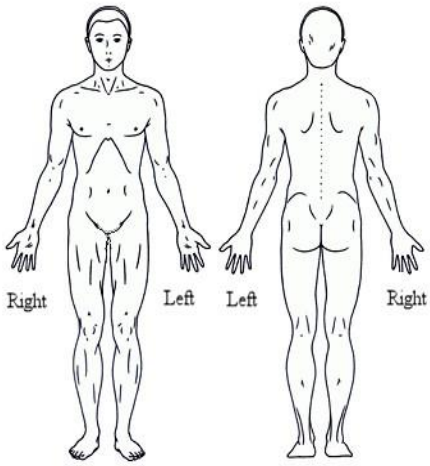
_____

Where Specifically Does it Hurt? (Check all that apply)

❑ Neck	❑ Upper Back	❑ Mid Back	❑ Lower Back	❑ Left Hip	❑ Right Hip
❑ Left Shoulder	❑ Right Shoulder	❑ Left Arm	❑ Right Arm	❑ Left Elbow	❑ Right Elbow
❑ Left Leg	❑ Right Leg	❑ Left Knee	❑ Right Knee	❑ Left Ankle	❑ Right Ankle
❑ Head	❑ Eyes	❑ Ears	❑ Chest	❑ Abdomen	❑ Buttocks

Other: _____

Please Describe the Pain and Place an "X" on the Picture:



Severity:
❑Mild ❑ Mild-to-Mod ❑Moderate ❑ Mod-to-Severe ❑ Severe

Frequency:
❑Once ❑ Intermittent ❑ Occasional ❑ Frequent ❑ Constant

Quality:
❑Dull ❑ Medium ❑ Sharp ❑ Stabbing ❑ Burning

The Pain is worse: (Check all that apply)
❑Morning ❑ Midday ❑ After Work ❑ Evening ❑ Nighttime

Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:

Circle One: 1 2 3 4 5 6 7 8 9 10

Have you Been Treated for this Current Condition in the Past?

❑ Yes ❑ No When?_____By Whom? _____

What Activities of Daily Living are you unable to perform due to your pain?

❑ Sleeping	❑ Walking	❑ Standing	❑ Sitting	❑ Running	❑ Climbing
❑ Bathing	❑ Showering	❑ Dressing	❑ Shoes	❑ Toileting	❑ Cleaning
❑ Self Care	❑ Family Care	❑ Child Care	❑ Home Care	❑ Driving	❑ Gardening
❑ Working	❑ Lifting	❑ Desk Work	❑ Traveling	❑ School	❑ Concentrate

Describe how the pain affects these Activities of Daily Living:

_____

Check the box that describes the pain and Activities of Daily Living (ADL):

1 – No Pain	**2 –** Slight Discomfort	**3 –** Pain with No Effect on ADL's	**4 –** Pain with a Little Effect on ADL's	**5 –** Pain Prevents Any ADL's	**6 –** Pain Limits Work and Prevents Any ADL's	**7 –** Pain Prevents Both Work and ADL's	**8 –** Pain Prevents Working, ADL's and Activity	**9 –** Pain Keeps Me in Bed or Sitting at All Times	**10 –** Pain is Horrible, Cannot Tolerate Movement

ADDITIONAL COMPLAINTS: _____

_____

PAST HISTORY:

What other conditions have you been treated for? (Explain in detail)

_____

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

Medical History – (Check all that apply)

You:

❑Diabetes	❑Arthritis	❑AIDS	❑Sciatica	❑Bursitis	❑Osteoporosis
❑Alzheimer	❑Kidney Disease	❑Gout	❑Amputation	❑Ulcers	❑High Blood Pressure
❑Cancer	❑Heart Attack	❑Stroke	❑COPD	❑Scoliosis	❑Low Blood Pressure
❑Ulcers	❑Deafness	❑Blindness	❑Migraines	❑Disc Disorder	❑Neuralgia
❑Constipation	❑Diarrhea	❑Nausea	❑Vomiting	❑Varicose Vein	❑Convulsions
❑Fainting	❑Sweats	❑Chills	❑Nervousness	❑Eczema	❑Prostrate Trouble
❑Bleeding	❑Tonsillitis	❑Earache	❑Hemorrhoids	❑Pregnancy	❑Neuro-Muscular Disease

❑Other: (Be specific) _____

Your Family:

_____

List any Current Allergies: (Be specific)

_____

Current Medications You are Taking: (Be specific)

_____

_____

Social Activities:

□ Smoke Cigarettes ____ # packs per day □ Smoke Cigars □ I don't smoke
□ Drink Alcohol Beverages ___ # per day, or ___ # per week □ I don't drink alcohol.
□ Beer □ Wine □ Mixed Drinks
□ I admit to history of Recreational Drug Use. □ I deny history of Recreational Drug Use.
□ I am currently Pregnant. Due Date: _____

Comments: _____

Please sign this form and thank you for visiting our office!

_____ _____

(Your Signature) (Date) Dr. Schauder (Date)