The Twisted Spine LLC. 206 S. Beach Street Daytona Beach FL. 32114 386-202-2272

Patient Intake Form

Doctors Use Only: **New Patient** **New Condition** **Exacerbation**

Patient Name:_____ Date:_____

Please print all information: All blanks must be filled in to allow us to serve you quickly and efficiently. Some sections may not apply to you, if that is the case circle NA **(Not Applicable)**. Your accurate responses will give a better understanding of you and your health. From this information we can provide you the best care possible.

No Change

O Male O Female

Date of Birth:_____ Height_____ Weight_____

E-mail Address:_____

Address:_____

Phone:_____

No Change

Primary Doctor's Name:_____

Address:_____

Phone:_____

I understand The Twisted Spine does **NOT** accept insurance:_____
(Signature and Date)

I do **NOT** participate in **Medicare** part **B**:_____
(Signature and Date)

History of Present Complaint

What Problem(s) or complaint(s) has brought you to the office today? _____
_____

Was this from a work related injury? No Yes
Was this from an automobile accident? No Yes
Was this from any type of trauma? No Yes (Explain)_____
Briefly give details of how and when this problem started: _____
_____
_____
Does anything make it better?_____
Does anything make it worse?_____
Describe the pain (Dull, Achy, Stabbing, etc.)?_____
Does the pain radiate(Leg, Arm, etc.)?_____
What time of day is the pain worse (Morning, evening, etc.) _____

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List all other physicians with whom you have consulted in the past year for this pain/problem

_____

Have you ever had surgery on your neck or back? No Yes (If yes how many times)_____
What Type of surgery ? NA Disectomy Laminectomy Fusion IDET Unknown
What Spinal Level? _____
Surgery Date(s)? _____

Do you have numbness in the groin or anal area? No Yes (how long)_____
Have you noticed any progressive muscle weakness especially in arms/legs? No Yes (how long)_____
Have you ever had any fractures (including compression) of the spine? No Yes (spinal level)

_____

Have you ever had adverse reaction to or following Chiropractic Care? No Yes (explain)

_____

Have you had Headache or neck pain unlike anything you have experienced before? No Yes
Have you ever had a stroke? No Yes (When)_____
Do you have any of the following symptoms? Band like trunk pain Decreased mobility
Vague non-specific lower limb symptoms Loss Control Bladder Loss Control Bowel None

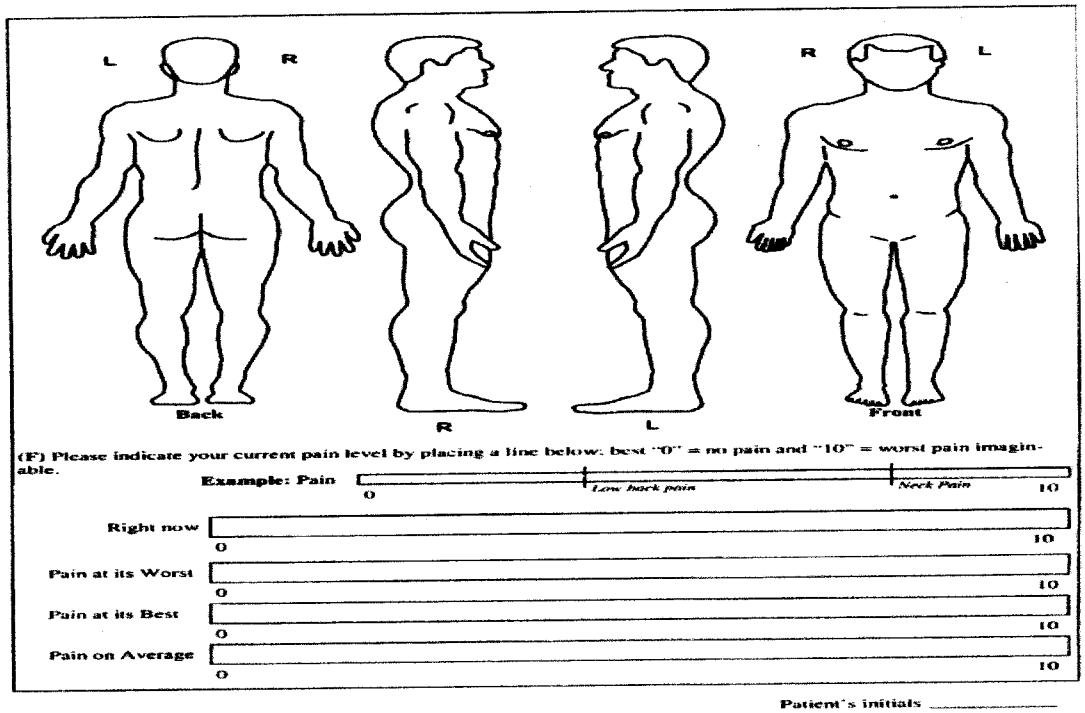
Physician's Use Only:
All information contained in this 4 page questionnaire was thoroughly reviewed on (Date):_____

Physicians signature:_____

Please Place an X on the image where your complaint/problem is located.

Draw a line on the pain scale indicating you level of pain

0=No pain 10= Worst pain imaginable



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Review of Systems: Check all that apply

General— NA
□Weight loss or gain
□Fatigue
□Fever or chills
□Weakness
□Trouble sleeping
Other_____

Skin- NA
□Rashes
□Lumps
□Itching
□Dryness
□Color changes
□Hair and nail changes
Other_____

Head- NA
□Headache
□Head injury
□Neck Pain
Other_____

Ears- NA
□Decreased hearing
□Ringing in ears
□Earache
□Drainage
Other_____

Eyes- NA
□Vision Loss/Changes
□Glasses or contacts
□Pain
□Redness
□Blurry or double vision
□Flashing lights
□Specks
□Glaucoma
□Cataracts
□Last eye exam
Other_____

Neurologic- NA
□Dizziness
□Fainting
□Seizures
□Weakness
□Numbness
□Tingling
□Tremor
Other_____

Nose- NA
□Stuffiness
□Discharge
□Itching
□Hay fever
□Nosebleeds
□Sinus pain
Other_____

Throat- NA
□Bleeding
□Dentures
□Sore tongue
□Dry mouth
□Sore throat
□Hoarseness
□Thrush
□Non-healing sores
Other_____

Neck- NA
□Lumps
□Swollen glands
□Pain
□Stiffness
Other_____

Breasts- NA
□Lumps
□Pain
□Discharge
□Self-exams
□Breast-feeding
Other_____

Respiratory- NA
□Cough
□Sputum
□Coughing up blood
□Shortness of breath
□Wheezing
□Painful breathing
Other_____

Psychiatric- NA
□Nervousness
□Stress
□Depression
□Memory loss
Other_____

Hematologic- NA
□Ease of bruising
□Ease of bleeding
Other_____

Cardiovascular- NA
□Chest pain or discomfort
□Tightness
□Palpitations
□Shortness of breath with activity
□Difficulty breathing lying down
□Swelling
□Sudden awakening from sleep with shortness of breath
Other_____

Gastrointestinal- NA
□Swallowing difficulties
□Heartburn
□Change in appetite
□Nausea
□Change in bowel habits
□Rectal bleeding
□Constipation
□Diarrhea
□Yellow eyes or skin
Other_____

Urinary- NA
□Frequency
□Urgency
□Burning or pain
□Blood in urine
□Incontinence
□Change in urinary strength
Other_____

Vascular- NA
□Calf pain with walking
□Leg cramping
Other_____

Musculoskeletal- NA
□Muscle or joint pain
□Stiffness
□Back pain
□Redness of joints
□Swelling of joints
□Trauma
Other_____

Endocrine- NA
□Head or cold intolerance
□Sweating
□Frequent urination
□Thirst
□Change in appetite
Other_____

Patient Intake Form

Past Medical History

Have you ever been hospitalized? No Yes
(explain)_____
Have you ever had any serious injuries or illnesses? No Yes
(explain)_____
Have you ever had the following Immunizations?
Pneumococcal (pneumonia) Unknown No Yes_____(year)
Hepatitis A Unknown No Yes_____(year)
Hepatitis B Unknown No Yes_____(year)
Tetanus/Diphtheria within last 10 years Unknown No Yes_____(year)
Influenza (Flu) Unknown No Yes_____(year)
Measles Unknown No Yes_____(year)
Mumps Unknown No Yes_____(year)
Rubella Unknown No Yes_____(year)
Polio Unknown No Yes_____(year)

Social History

Highest level of education? _____
Current employment status? Un-employed retired Homemaker Student employed
Marital Status? Divorced Widowed Single Married (Spouse name)_____
Do you use any of the following substances?
Caffeine (How much/Often)_____
Tobacco (How much/Often)_____
Alcohol (How much/Often)_____
What does your diet consist of?
_____

Family History (Please circle all that apply)

Mother: Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Father: Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Brother (s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Sister (s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Grandmother(s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Grandfather(s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Daughter (s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____
Son(s): Cancer Diabetes Heart disease High blood pressure High Cholesterol Liver disease
Psychiatric illness Tuberculosis Alcohol/Drug abuse Other_____

Please List All Prescription or Supplement Medications You are Currently Taking

Drug Name	Strength	Usage