# FORT WAYNE SPINE & JOINT

NEW CASE INTAKE

**Name:** _____ **Date:** _____

**What brings you to our office today?** _____

**1. Who is your primary care physician/provider (M.D./D.O.)?**

Name: _____

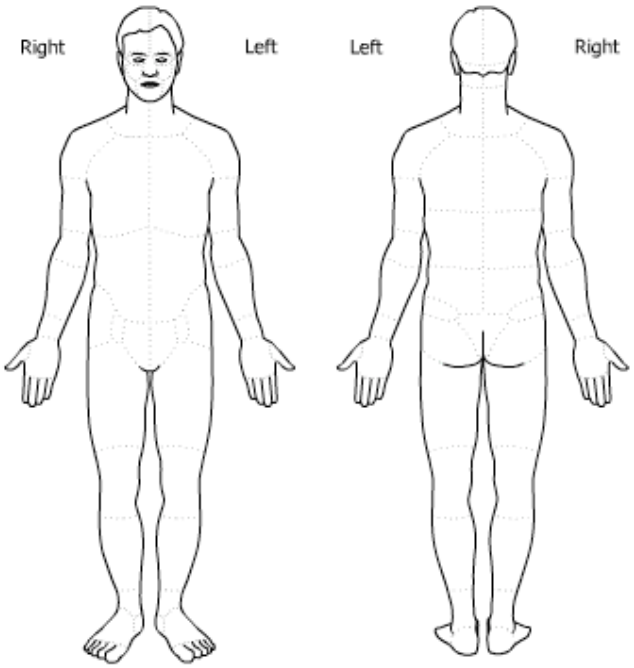
**May we contact them for records and send them notes from treatments rendered here?** _____

**2. Have you been treated for this condition before? (Circle one)** Yes No

If yes, by whom: _____

**3. Please mark the body where you feel described sensations, using the appropriate letters. Rate your pain from 1 (very mild pain) to 10 (worst pain you can imagine) on the scale to the right.**

| **Aching** | A | **Burning** | B | **Throbbing** | T | **Numbness** | N | **Pins & Needles** | P |
|---|---|---|---|---|---|---|---|---|---|




Please rate your pain with a number below (0 = no pain, 10 = worst pain)

**Neck/Shoulder/Arm Pain**

_____

**0 5 10**

**Mid Back Pain**

_____

**0 5 10**

**Low Back and Leg Pain**

_____

**0 5 10**

**4. How long have you had this pain?**

_____ Years _____ Months _____ Weeks _____ Days

**Signature:** _____ **Date:** _____

**5. How did the pain begin?**

Unsure Fall/Injury Lifting/Moving Something Woke up with pain Other

**Please explain:**

_____

_____

**6. How frequently do you experience pain?** (Circle one please)

Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-0%)

**7. What makes it better?**

Ice Heat Medications Massage Other Nothing helps

**8. What makes it worse/activities limited by pain?**

| | | | | |
|---|---|---|---|---|
| Bending | Coughing | Daily routine | Driving | Bowel movements |
| Getting up | Lifting | Lying down | Pulling | Pushing |
| Reading | Sitting | Sleeping | Sneezing | Standing |
| Turning head | Urination | Walking | Working | Other: _____ |

**9. Associated symptoms/other notes:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Headaches | | Ear Ringing | | Blurred Vision | | Loss of appetite |
| | Weight Loss | | Bowel/bladder Issues | | Dizziness | | Nausea |

**11. Where do you work?_____**

**12. What do you spend most of your time doing at work?**

Work habits (circle): Sitting Standing Light Labor Heavy Labor

**13. How do you sleep at night? Roughly how many hours?**

Back _____ Side (L/R) _____ Stomach _____ Hours _____

**14. Have you had a X-ray or MRI of the area?** X-ray: _____ MRI: _____

If yes, where was it taken and how long ago? **_____**

**15. Have you been to a chiropractor before? If yes, how long ago?**

_____

**16. What are your goals for care?**

Please Explain:_____

_____

**Signature:** _____ **Date:** _____