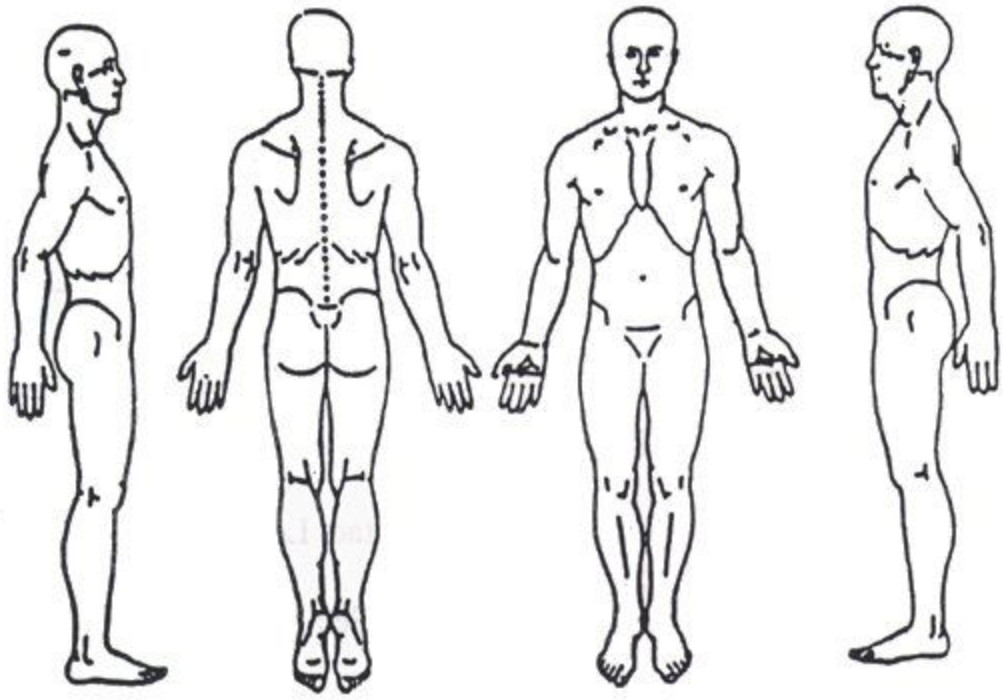
Neck and Back Pain Relief Dr. Timothy Price, *Doctor of Chiropractic*

PATIENT INTAKE FORM

Name: _____ Date: _____

1. Please indicate general health. ☐ Excellent ☐ Good ☐ Average ☐ Poor
2. Indicate on the drawings below where you have pain/symptoms by marking the area with an "X". Please mark ***ALL*** areas of pain.
3. Using a scale from 0-10 (10 being the worst), how would you rate your problem? On the drawing below, please rate you pain level next to the "X" that you used to mark the location of your pain.



4. How often do you experience your symptoms?
   ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
   ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)
5. How would you describe the type of pain?
   ☐ Sharp ☐ Dull ☐ Stiff ☐ Numb ☐ Tingly ☐ Other: _____
6. Who else have you seen for your problem?
   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician ☐ Orthopedist
   ☐ Massage Therapist ☐ Physical Therapist ☐ Other: _____
7. How do you think the problem began? _____
8. When was the most recent flare-up? _____
9. What aggravates your problem? _____
10. What relieves your problem? _____
11. What does your problem prevent you from doing? What would you like to improve your ability to do?

_____

PATIENT SIGNATURE: _____ Date: _____