



36530

DC Patient Intake Form

(version 1.1)

www.palladianhealth.com/members

Palladian

Last name

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First name

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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | |
|--|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Headache |
| <input type="radio"/> Upper/
mid back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Other |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | |

2. When did this problem first begin?

-
- Less than 1 month ago
-
- 1-3 months ago
-
- 4-6 months ago
-
- 7-12 months ago
-
- More than 1 year ago

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)? No Yes4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)? No Yes5. ... recently been evaluated by a medical doctor? No Yes**Since this problem began, have you noticed...**

No Yes

6. ... so much weakness in both your arms that you are unable to lift them? No Yes7. ... so much weakness in both your legs that you are unable to walk without help? No Yes8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate? No Yes9. ... pain in your chest, shortness of breath, or coughing up blood? No Yes10. ... that one leg felt more warm, more swollen, more red, or more tender than the other? No Yes**Have you recently...**

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting? No Yes12. ... had any type of infection, fever, or chills? No Yes13. ... had any type of surgery, surgical procedure, or medical procedure? No Yes14. ... lost a lot of weight without really trying to (i.e. without being on a diet)? No Yes15. ... had any type of accident, fall, or trauma? No Yes**Have you ever...**

No Yes

16. ... been diagnosed with cancer? No Yes17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)? No Yes18. ... been diagnosed with a weakened immune system? No Yes19. ... used any injected drugs (i.e. non-prescription drugs)? No Yes20. ... used steroids such as prednisone for more than 4 weeks? No Yes**Is this problem something that ...**

No Yes

21. ... you've had before? No Yes22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise? No Yes23. ... generally gets better (i.e. less severe or frequent) with rest? No Yes24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan? No Yes25. ... is also being treated by a health professional other than a chiropractor? No Yes

Service Date:

M	M	/	D	D	/	Y	Y	Y	Y										

36530



PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name																				First Name																		
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1. In general, would you say your health is

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Yes, limited a lot	Yes, limited a little	No, not limited at all
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Climbing several flights of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Were limited in the kind of work or other activities

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Did work or other activities less carefully than usual

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These questions are about how you feel and how things have been with you during the past week.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...

9. Have you felt calm and peaceful?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Did you have a lot of energy?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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11. Have you felt downhearted and depressed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date: / /
M M / D D / Y Y Y Y

