Community Chiropractic

Shoulder Intake Form

Legal Name ______________________________ Preferred Name ____________

Birth Date ____________________ Height ________ Weight ________

Address ____

Cell Phone ____________________ Email ___________________________

Marital Status S M D W Spouse Name _____________ Phone ____________

Emergency Contact Name ______________________ Phone _______________

Are there any other family members/friends who are involved in your health/financial decisions?

If so: Name __________________________ Phone __________________

Occupation (Current or Previous) _________________________ Retired? Y N

How did you hear about our office? TV Facebook Seminar Mailer Other _______________

What is the main health concern for this appointment? ______________________________

When did your symptoms start? ______________________________________

Is there anything that makes them worse? ______________________________

Is there anything that makes them better? ______________________________

How would you describe your symptoms? *(Circle all that apply)*

Aching Burning Cold Cramping Dead Feeling Electric Shocks

Fatigue Numbness Pins & Needles Sharp Pain Stabbing Pain Stiffness

Stinging Swelling Throbbing Pain Weakness

Are your symptoms interfering with any of the following? *(Circle all that apply)*

Chores Daily Routine Exercise Lifting Sleep Walking Working Other ____________

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How frequent are your symptoms?
___Constant (75-100%) ___Frequent (51-75%) ___Occasional (25-50%) ___Intermittent (25% or less)

On average, how severe is your overall shoulder pain?

None 1 2 3 4 5 6 7 8 9 Worst Possible Pain

How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

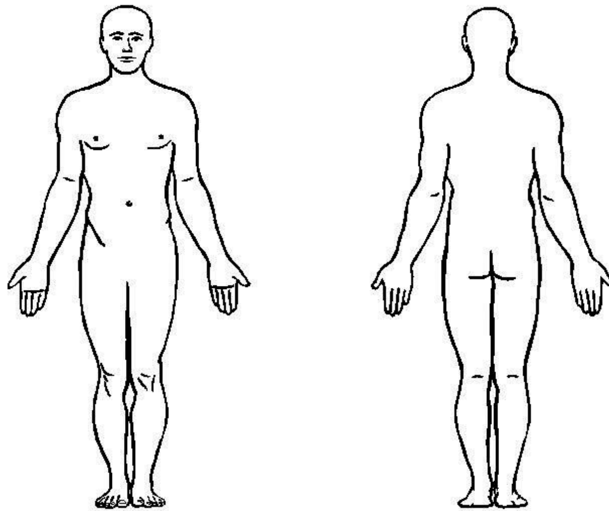
Please indicate on the drawings the body area(s) you are experiencing symptoms…

Which shoulder is bothering you?

___ Left

___ Right

___ Both



Have your symptoms changed over time? Stayed the Same Gotten Better Gotten Worse

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Treatment History

Primary Care Physician ____ Phone ___________________

Do we have your permission to send them records of your visits here if they request us to? Y N

Have you used pain or anti-inflammatory medications (Tylenol, Aspirin, Aleve, Advil, Meloxicam, Pain Creams, etc.) for at least 3 months without long-term relief? _____________________________________

Have you tried physical therapy? Y N If yes, how long? ____________________________

Have you had steroid or cortisone injections in your neck, shoulder, or arm? Y N When? __________

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Have you had any surgeries on your neck, shoulder, or arm? Y N

If yes, what surgery and when did it occur? ____
____

Have you had an MRI or X-Ray on your neck, shoulder, or arm? Y N When? _______________

How many doctors have you seen for this condition? ____

Have the things you have tried so far for this condition helped? Yes No Somewhat Unsure

Please list any medical conditions you have had (diagnosed conditions, major surgeries, etc.)

____

____

Circle **Y**es or **N**o for each condition listed below:

Y N Lower Back Pain	Y N Vascular Problems	Y N Heart Attack
Y N Shoulder/Arm Numbness	Y N Joint Replacements	Y N Stroke
Y N Shoulder/Arm Pain	Y N Shoulder Surgeries	Y N High Cholesterol
Y N High Blood Pressure	Y N Hand Problems	Y N Sciatica
Y N Hand Pain/Numbness	Y N Spinal Surgeries	Y N Cancer
Y N Neck Pain	Y N Vascular Surgeries	Y N Neuropathy
Y N Spinal Arthritis	Y N Diabetes (last A1c=_____)	Y N Gout
Y N Kidney Disease	Y N Shingles	Y N Heart Problems

Please list any medications and/or vitamins you are currently taking (or attach a list to this form)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

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Are you currently taking a **blood thinner**? (Coumadin, Lovenox, Heparin, etc.) Y N

Are you currently taking a **statin**? (Atorvastatin, Lipitor, Crestor, Simvastatin, etc.) Y N

Do you have an **electrical implant** of any kind? (spinal stimulator, bladder stimulator, ect.) Y N

Alcohol Use: __Never __Rarely __Moderately __Daily #_____ __Former User

Tobacco Use: __Never __Rarely __Moderately __Daily #_____ __Former User

Other Drug Use: __Never __Rarely __Moderately __Daily #_____ __Former User

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Life Quality and Goals Survey

List some specific activities you can no longer do or are struggling with because of your symptoms.

________________________________ ________________________________

________________________________ ________________________________

If this problem continues to get worse, what do you envision your life will be like? *Please be specific.*

____

____

What would be different if this problem was gone? *Please be specific.*

____

____

For the treatments in our office to be considered successful to you, what would need to happen? What results would you like to see?

____

____

Community Chiropractic
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For each of the following questions, please circle the number that best describes your pain…
0 = no pain   10 = the worst pain imaginable

At its worst?   0 1 2 3 4 5 6 7 8 9 10

When lying on the involved side?   0 1 2 3 4 5 6 7 8 9 10

Reaching for something on a high shelf?   0 1 2 3 4 5 6 7 8 9 10

Touching the back of your neck?   0 1 2 3 4 5 6 7 8 9 10

Pushing with the involved arm?   0 1 2 3 4 5 6 7 8 9 10

Please circle the number that best describes your ability to complete the following tasks…

0 = no difficulty completing task   10 = unable to perform task

Washing your hair   0 1 2 3 4 5 6 7 8 9 10

Washing your back   0 1 2 3 4 5 6 7 8 9 10

Putting on a shirt or sweater   0 1 2 3 4 5 6 7 8 9 10

Putting on a shirt with buttons down the front   0 1 2 3 4 5 6 7 8 9 10

Putting on your pants   0 1 2 3 4 5 6 7 8 9 10

Placing an object on a high shelf   0 1 2 3 4 5 6 7 8 9 10

Carrying an object of 10 pounds or more   0 1 2 3 4 5 6 7 8 9 10

Removing something from your back pocket   0 1 2 3 4 5 6 7 8 9 10

By signing this form, I…

- Certify that all information I have listed is accurate and complete to the best of my knowledge.
- Agree to allow the doctor to discuss any relevant information with other practitioners or staff in order to better serve me.

____   ____________________

Patient Signature   Date