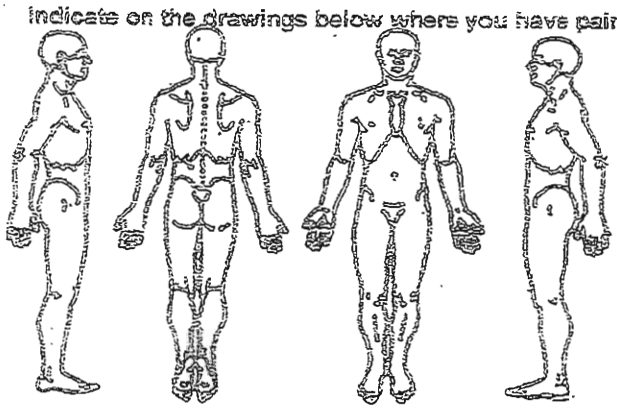
Dr. Castro Patient Intake Form

Patient Name: _____ Date: _____
Address: _____ City: _____ State: _____ ZIP: _____
Home Phone (___) ___-____ Cell Phone (___) ___-____ Referred by: _____
Email Address: _____
Height: _____ Weight: _____ Age: _____ Date of Birth: _____
Social Security No.: _____ __Married __Single __Widowed __Other
Occupation: _____ Employer: _____ Work Phone (___)___-____
Spouse's Name: _____ Spouse's number (___)___-____
Emergency Contact Name: _____ Contact Phone (___) ___-____
Is today's problem caused by: Y/N Auto Accident Y/N Workers' Compensation. Other: _____?

Indicate on the drawings below where you have pain/symptoms



How often do you experience your symptoms?
□Constantly □ Occasionally
□ Frequently □ Intermittently

How would you describe the type of pain?

__Sharp	__Numb
__Dull	__Tingly
__Sharp with motion	__Shooting with motion
__Achy	__Stabbing with motion
__Burning	__Shooting
__Stiff	__Other: _____

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?
□ Not at all □ A little bit □ moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

How long have you had this problem? _____
How do you think your problem began? _____

Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

What aggravates your problem?
_____

Do you smoke Tobacco Products? Y/N What? _____ How many/Day? _____ When? _____
Drink Coffee/Soda/soft drinks? Y/N What? _____ How many/Day? _____ When? _____
Alcoholic Beverages? Y/N What? _____ How many/ Day? _____ Since When? _____

X-ray History: Include cat, MRI, Dye studies and Dental

_____

_____

List all prescription medications you are currently taking:

_____

List all of the over-the-counter medications/supplements you are currently taking:

_____

List all surgical procedures you have had:

_____

Have you ever been hospitalized? ___ No ___ Yes

If yes, why:_____

Have you had significant past trauma? ___ No ___ Yes

If yes, what:_____

Anythin else pertinent to your visit today?_____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer			
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumor	☐	☐	Muscular In coordination			
☐	☐	Asthma	☐	☐	Visual Disturbances			
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			
☐	☐	Other: _____						

Patient Signature: _____ Date: _____