Dr. Dan S. Monson D.C. 801-966-5200

Patient Intake Form-Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:_____ **Date:**_____ □ male □ female

Marital status

S	M	W	D	SEP

Insurance Co:_____ **Date Of Birth:**_____

Address:_____ **City, State, Zip:**_____

Cell:_____ **Home:**_____ **Work:**_____ **Occupation:**_____

Email:_____ **Employer:**_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing:_____

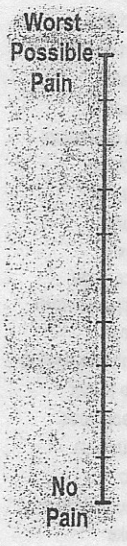
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

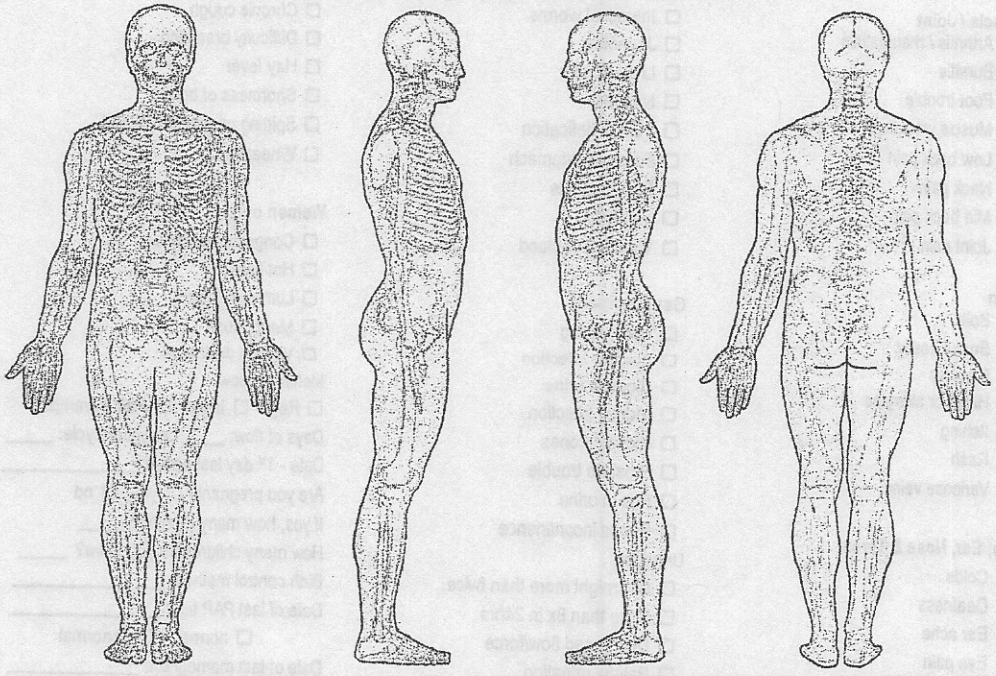
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

When was your last auto accident? _____

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	
... had any mental disorders?	□	□	
... had any broken bones?	□	□	
... had any strains or sprains?	□	□	
... ever used orthotics?	□	□	
Do you take minerals, herbs or vitamins?	□	□	

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history *If any blood relative has had any of the following conditions, please check and indicate which relative(s)*

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleed easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: ____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? ____
How many children do you have? ____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mamogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ *Numbness/tingling*
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications you are currently taking and why:

_____

_____

_____

_____

By my signature below I certify that I have answered all questions to the best of my knowledge:

Signature _____ Date _____

If under 18 years old: I hereby give consent and authorize the doctor to administer chiropractic care as deemed appropriate to my (indicate relationship to YOU)_____.

Signature _____ Date _____

Functional Rating Index

Name_____

In order to properly asses your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday abilities . For each item below, please CIRCLE the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild Pain	Moderate	Severe	Cannot Function

2. Sleeping

0	1	2	3	4
No pain	Mild Pain	Moderate	Severe	Cannot Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain	Mild Pain	Moderate	Severe	Cannot Function

4. Travel

0	1	2	3	4
No pain On long trip	Mild Pain on long trip	Moderate pain on long trip	Severe pain on long trip	Severe pain on long trip

5. Work

0	1	2	3	4
Can do usual Work Plus Extra	Can do usual no extra	Can do 50% of usual work	Can do 25% of usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do all Activities	Can do most Activities	Can do some Actvities	Can do few Activities	Cannot do any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Pain 25% of the day	Pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. Lifting

0	1	2	3	4
No pain heavy weight	Increased pain / heavy weight	Increased pain/ moderate weight	Increased pain/ light weight	Increased pain/ any weight

9. Walking

0	1	2	3	4
No pain/ any distance	Increased pain after 1 mile	Increased pain/ after ½ mile	Increased pain/ after ¼ mile	Increased pain all walking

10. Standing

0	1	2	3	4
No pain after Several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

_____ _____

Patient Signature Date