Baltimore
BACK & PAIN CENTER
Michael A. Dorn, Jr., Doctor of Chiropractic
410.662.4476
3914 Hickory Avenue
Baltimore, MD 21211

Initial Intake Form

FOR OFFICE USE ONLY
B: Y / N **Q:** Y / N
ROF:
M T W TH FR
@ _____
___ / ___ / ___

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (State) (Postal Code)

Soc. Sec. #: ____-___-_____ Marital status: _____ Occupation&Employer: _____

Home Ph. #: _____ Cell: _____ Work: _____

Email: _____ Emergency Contact: _____ #: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

How did you hear about us? ☐ Internet ☐ Friend ☐ Phone call ☐ Ad ☐ Other: _____

INSURANCE INFORMATION (Please, do not leave anything blank)

Please check any/all insurance coverage that may be applicable in this case: ☐ Health Ins ☐ Work Comp ☐ AUTO (PIP)

Primary Insurance: _____ Secondary Insurance: _____

Name of POLICY HOLDER: _____ Birthday of *Policy Holder* (M/D/Y): _____

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

_____
_____
_____
_____
_____

How long have you had this condition? _____ Since it began, is it: ☐ Same ☐ Better ☐ Worse

What seemed to be the initial cause:

_____

What activities aggravate your condition/pain?

_____

What activities lessen your condition/pain?

_____

Is this condition worse during certain times of the day? ☐ Yes ☐ No If yes, when?_____

Is this condition interfering with ☐ Work ☐ Sleep ☐ Routine ☐ Other?_____

Other Doctors seen for this condition: _____

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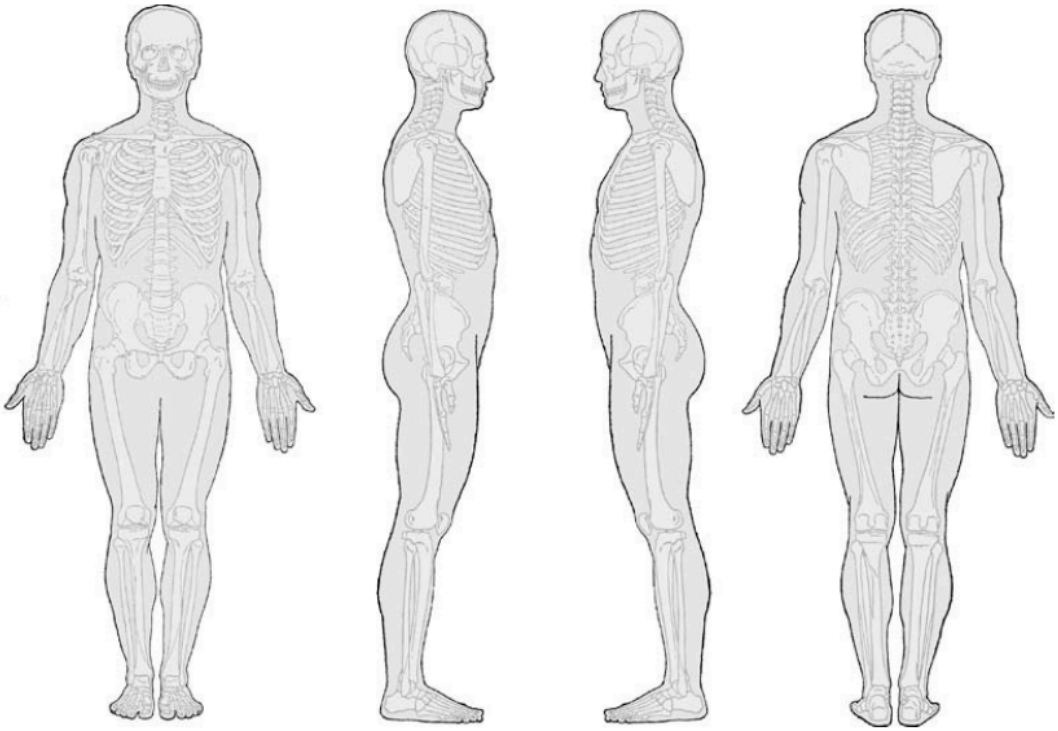
Any home remedies?

_____

_____

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



Height: _____ Weight: _____

HOSPITALIZATIONS, SURGERIES, MAJOR ACCIDENTS/INJURIES, X-RAYS, CAT SCANS, MRIS, EKGS, ETC

(PLEASE USE BACK OF THIS PAGE TO COMPLETE THIS SECTION, IF NECESSARY)

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

READ THE FOLLOWING QUESTIONS AND FILL IN THE NUMBER THAT APPLIES:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

☐ Alcohol ☐ Artificial sweeteners ☐ Candy or other sweets

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- ☐ Pop/soda
- ☐ Chewing tobacco
- ☐ Cigarettes
- ☐ Cigars/pipes
- ☐ Coffee
- ☐ Tea

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticonvulsants
- ☐ Antidepressants
- ☐ Antifungals
- ☐ Aspirin/Ibuprofen
- ☐ Asthma inhalers
- ☐ Beta blockers
- ☐ Birth control
- ☐ Chemotherapy
- ☐ Cortisone
- ☐ Diabetic medications
- ☐ Diuretics
- ☐ Heart medications
- ☐ High blood pressure
- ☐ Hormone Therapy
- ☐ Laxatives
- ☐ Insulin
- ☐ Recreational drugs
- ☐ Relaxants/Sleeping
- ☐ Thyroid medication
- ☐ Pain medication
- ☐ Ulcer medications
- ☐ Other:_____

Indicate with a check mark any symptoms that apply (**past** *and* **present**)

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Low Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Dizziness
- ☐ Pain Between Shoulders
- ☐ Neck Stiff
- ☐ Joint Swelling
- ☐ Fever
- ☐ Loss of Balance
- ☐ Pain in Hands or Arms
- ☐ Numbness in Hands or Arms
- ☐ Pain in Legs or Feet
- ☐ Numbness in Legs or Feet
- ☐ Fatigue
- ☐ Depression
- ☐ Sensitivity to light
- ☐ Loss of Memory
- ☐ Shoulder Pain
- ☐ Sinus
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Allergies
- ☐ Chest Pains
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Painful Urination
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Heartburn/Reflux
- ☐ Weight Loss
- ☐ Loss of Smell or Taste

HIPPA FORM

- ❑ Ringing in Ears
- ❑ Jaw/TMJ Problems
- ❑ Cold Hands
- ❑ Cold Feet
- ❑ Menstrual Cramps
- ❑ Menopause