PATIENT INTAKE FORM
Pennsylvania Chiropractic and Rehab, LLC
Dr. Jason Cozart

Patient Name: _____DOB_____Age_____
Date: _____
Address_____City, State, Zip_____
Home Phone_____Work Phone_____Other _____
email address_____
M or F Marital Status_____Spouse Name_____# of Children_____

SS#_____ **Preferred Language:**_____

Who is the insured member or if self pay, who is responsible for the account?
_____

Referred by?_____

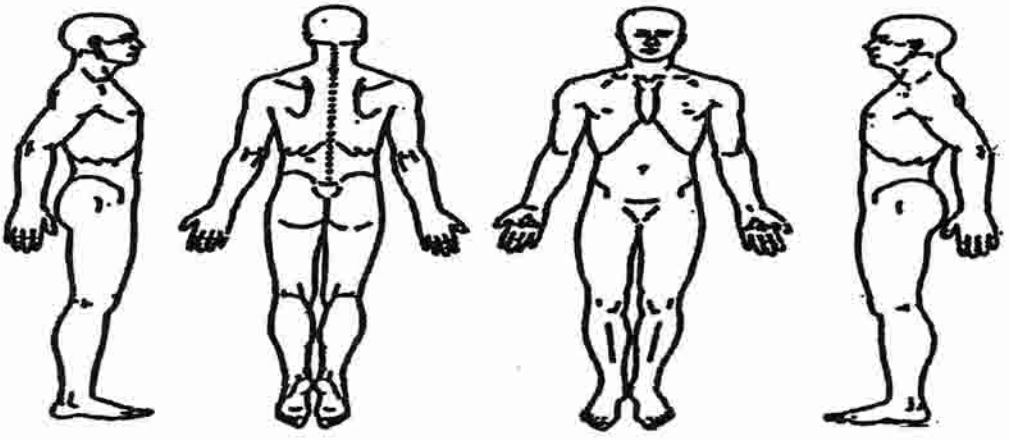
Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino

Race: □ American Indian or Alaskan Native
□White
□Asian
□Black or African America

Smoking Status: □ Current Everyday
□ Current Someday
□ Former
□ Never

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms for Your #1 Problem



3. How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:_____

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

6. 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*)

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

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

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

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

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

13. What aggravates your problem?

_____

14. What relieves your problem?

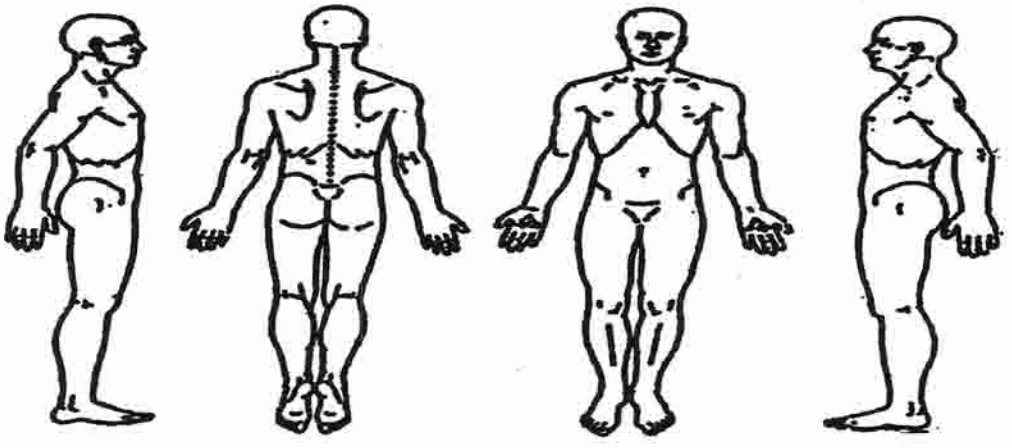
_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

<u>16-29 is for your second or other problem areas (Start again at #30 if no additional problems)</u>

16. Indicate on the drawings below where you have other pain/symptoms



17. How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

18. How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ Other:_____

19. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

20. 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*)

21. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

22. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

23. Who else have you seen for your problem?

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	□ No one

24. How long have you had this problem? _____

25. How do you think your problem began?

_____

26. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

27. What aggravates your problem?

_____

28. What relieves your problem?

_____

29. What concerns you the most about your problem; what does it prevent you from doing?

_____

Everyone must fill out #30 and after

30. What is your: Height_____ **Weight** _____ **Age** _____

Occupation _____

31. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

32. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

33. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

Other?_____

_____

34. 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 Dependance
□	□	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/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

35. List all prescription medications you are currently taking:

_____

36. List any Drug Allergies and reaction:

_____

37. List all of the over the counter medications you are currently taking:

_____

38. What supplements/vitamins are you taking:

_____

39. List all surgical procedures you have had:

_____

40. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

41. What activities do you do outside of work?

_____

42. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

43. Have you had Chiropractic treatment before? □ No □ Yes

If yes, where and when?_____

44. Have you had significant past trauma? □ No □ Yes

45. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Pennsylvania Chiropractic and Rehab Ctr.
1159 6th Street
Waynesburg, PA 15370
724-852-4222

Due to missed appointments from multiple patients, we are going to be more strict on office visit cancellations / No Show policies.

As already posted in each room in our office and on the initial paper work signed, you can see that we ask for a 24 hour notice for cancellations. **Cancellations of less than 12 hours or any No Shows will receive an office charge of $35.**

If this may be a problem due to work or family, please discuss this before with the doctor. We try to be flexible, but it is being taken advantage of

Not showing up for appointments keep others from using these times. We try not to overbook to prevent long waits. Therefore, last minute cancellations and especially not showing up may cause us to start overbooking like other doctor's offices which will cause much longer wait times.

Please sign to show you understand and agree to follow this policy.

X_____ Date _____