Dr. Scott Lawrence

~NEW PATIENT INTAKE FORM~

Name: _____ Today's date_____

Address: _____ City: _____

Cell: _____ Email Address: _____

Teudat Zehut: _____ Birth date: _____ Age: _____ sex: (M / F)

Occupation: _____

Have you seen a Chiropractor before? Yes No If yes, When? _____

Whom may we thank for referring you to our Office? _____

YOUR HEALTH SUMMARY

***PRIMARY HEALTH COMPLAINT OR GOAL_____**

_____

Check all symptoms you have had, even if they do not seem related to your current problem

☐ Headaches	☐ Loss of smell	☐ Ringing in ears	☐ Nervousness
☐ Tingling in arms	☐ Buzzing in ears	☐ Loss of taste	☐ Stomach upset
☐ Tingling in legs	☐ Depression	☐ Irritability	☐ Tension
☐ Fatigue	☐ Neck stiffness	☐ Cold hands	☐ Fever
☐ Sleeping problems	☐ Constipation	☐ Cold feet	☐ Hot flashes
☐ Diarrhea	☐ Lights bother you	☐ Problem urinating	☐ Heartburn
☐ Cold sweats	☐ Menstrual pain	☐ Menstrual Irregularity	☐ Ulcers
☐ Mood swings	☐ Fainting	☐ Neck pain	☐ Nervousness
☐ Dizziness	☐ Back pain	☐ Loss of balance	☐ Stomach upset

Medication you are taking: _____

The statements made on this form are accurate to the best of my recollection & I agree to allow the office to examine me for further evaluation.

Patient Signature_____ Date_____ 07/22/18

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Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
	In the past 7 days…					
15	How run-down did you feel on average?	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
16	How fatigued were you on average?	☐	☐	☐	☐	☐

PROMIS–29 Profile v1.0

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)……	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity

In the past 7 days…

29	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

