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) (Postal Code)

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

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

Email: _____ Name of Medical Doctor: _____

Permission to contact for labs, etc. Y/N

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. 4. _____
2. _____ 5. 5. _____
3. _____ 6. 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: _____

Any home remedies?

_____
_____

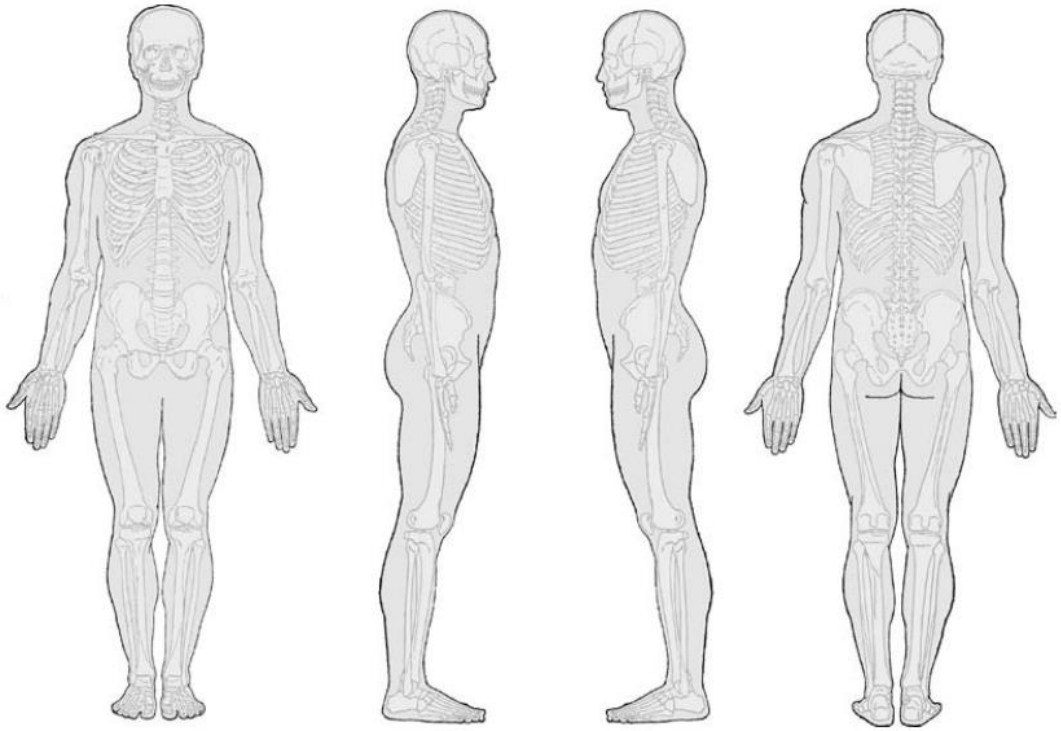
Initial:_____

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

Initial Intake Form

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: _____

LIST 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	☐ Pop/soda	☐ Cigars/pipes
☐ Artificial sweeteners	☐ Chewing tobacco	☐ Coffee
☐ Candy or other sweets	☐ Cigarettes	☐ Tea

Initial:_____

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

Initial Intake Form

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

Initial:_____