Brink Chiropractic Clinic
1047 Main St
Sanford, ME 04073
Phone: 207-324-5753
Fax: 207-324-8354

# Patient Intake Form

Once completed, please save this document to your computer or device and email the document as an attachment to info@brinkchiropractic.com.

## Demographic & Contact Information

First Name:
Last Name:
Birth Date:
SSN:
Address
Primary Phone
Cell Phone
Address 2
Work Phone
Home Phone
City
State/Province
Postal Code
E-Mail
Preferred Communication
Preferred Reminder Format
Preferred Language
Smoking Status

## Gender, Race and Ethnicity

Gender
Gender Identity
Sexual Orientation
OMB Ethnicity
CDC Ethnicity
OMB Race
CDC Race

## Current Medications

| Medication | Reason | Start Date |
|---|---|---|
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## Medication Allergies

| Medication | Reason | Symptom |
|---|---|---|
| | | |
| | | |
| | | |

## Allergies (Check all that apply)

☐ Adhesives ☐ Latex ☐ None ☐ Rubber ☐ Soaps ☐ X-ray Dye

## Surgeries (Check all that apply)

☐ Abdominal ☐ Angioplasty ☐ Appendix ☐ Arm ☐ Back ☐ Back (Disc) ☐ Back (Fusion) ☐ Bladder
☐ Bone Spurs ☐ Brain ☐ Breast ☐ CAD ☐ Cardiac Stent ☐ Carpal tunnel ☐ Cervical Disc
☐ Cervical fusion ☐ Chest ☐ COLOSTOMY ☐ C-SECTION ☐ Discectomy ☐ Dorsal release ☐ Ear
☐ Elbow ☐ Eye ☐ Face ☐ Foot ☐ Gallbladder ☐ Gasrtic Bypass ☐ Gynecological ☐ Hand ☐ Heart
☐ Hernia ☐ Hip ☐ Hysterectomy ☐ Joint Replacement ☐ Kidney ☐ Knee ☐ Leg ☐ Liver
☐ Lumbar fusion ☐ Lung ☐ Neck ☐ Neurological ☐ None ☐ Nose ☐ Oral ☐ Plantar fascitiis
☐ PROSTATE ☐ RCA ☐ Shoulder ☐ Skin ☐ STENT IN HEART ☐ STENTS ☐ Throat ☐ Thyroid
☐ TMJ ☐ Toes ☐ Tonsilectomy ☐ Tubes in Ears ☐ Wrist ☐ UNKNOWN ☐ BREAST Augmentation
☐ CATARACT ☐ GERD ☐ OVARIAN CANCER ☐ Hemorrhoid ☐ HERNIA ☐ NONE NOTED
☐ UMBILICAL HERNIA ☐ WISDOM TEETH

## Medical History (Check all that apply)

☐ Abnormal weight gain ☐ Abnormal weight loss ☐ Anemia ☐ Aneurysm ☐ Angioplasty ☐ Ankle Pain
☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Blood Clots ☐ Broken Bones ☐ Cancer
☐ Chest Pain ☐ Chills ☐ COPD ☐ Corticosteroid use ☐ Degenerative Disc
☐ Depression/Other disorder ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems
☐ Fainting ☐ Falls within the last 12 months ☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Disorder ☐ GERD
☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Heart Attack ☐ Heart disease ☐ Hepatitis
☐ High Blood Pressure ☐ High Cholesterol ☐ Hip Pain ☐ Hypothyroidism ☐ Insomnia ☐ Jaw Pain
☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Low Back Pain ☐ Marked Morning Pain/Stiffness
☐ Marked morning stiffness ☐ Menstrual Problems ☐ Mid Back Pain ☐ Migraine ☐ Multiple Sclerosis
☐ Neck Pain ☐ Nerve Damage ☐ Neurological Disorder ☐ Neuropathy ☐ NONE
☐ Numbness in Groin/Buttocks ☐ Osteoarthritis ☐ Osteoporosis ☐ Pacemaker ☐ Pain at Night
☐ Pain Unrelieved by Position or Rest ☐ Polio ☐ Prostate Problems ☐ PTSD ☐ Pulmonary Embolism
☐ Recent Fever or Chills ☐ Restless leg Syndrome ☐ Rheumotid Arthritis ☐ Scoliosis ☐ Seizures
☐ Shoulder Pain ☐ Sinus Problems ☐ Skin Cancer ☐ Sleep Apnea ☐ Spinal Cord Injury
☐ Sprain/Strain ☐ Stomach Problems ☐ Stroke/Heart Attack ☐ Taking Birth Control Pills
☐ Taking Blood Thinners ☐ Thyroid ☐ Urinary Problems ☐ Vertigo ☐ Visual Disturbances ☐ Wrist Pain
☐ Factor V Liden ☐ CKD ☐ Fibromyalgia ☐ BIRTH CONTROL ☐ BLOOD THINNERS

## Social History (Check all that apply)

☐ Smoking/tobacco use ☐ Working ☐ Being married ☐ Being single ☐ Disability ☐ Exercising regularly

## Custom (Check all that apply)

## Family History

| Family Member | Condition |
| --- | --- |
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## Accidents

| Accident Type | Details |
| --- | --- |
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| | |
| | |

## Tell us about your symptom(s) today. Symptom #1

Symptom

Symptom Start Date

☐ Experienced before?

## On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

## What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

## What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

## What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp ☐ Shooting ☐ Stabbing pain ☐ Tightness
☐ Tingling ☐ Throbbing

## What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Occasionally (26 - 50% of the day) ◯ Intermittently (0 - 25% of the day)

## What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing works
☐ Pain Medicines ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy ☐ Other

## What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending ☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs ☐ Concentrating ☐ Cooking/Cleaning
☐ Crouching/Squatting ☐ Doctor's visits ☐ Doing Hobbies ☐ Doing things on time ☐ Dressing ☐ Driving
☐ Eating ☐ Exercise/Sports ☐ Financial Management ☐ Gardening ☐ General Mobility
☐ Getting Places ☐ Hearing ☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance
☐ Knitting ☐ Leaning ☐ Lifting ☐ Light/Sound ☐ Lying down ☐ Making decisions ☐ Moving Joint/s
☐ Mowing ☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Seeing ☐ Sewing ☐ Sexual Activity ☐ Shopping
☐ Sitting ☐ Speaking ☐ Standing ☐ Turning ☐ Twisting ☐ Using the phone ☐ Walking
☐ Watching TV ☐ Working ☐ Yard work

## What are your expectations regarding this symptom?

- [ ] Become Pain Free
- [ ] Explanation of my Condition
- [ ] Learn how to care for this condition on my own
- [ ] Reduce Symptoms
- [ ] Resume Normal Activity

If you have additional symptoms to record, please continue on the next page.

## Tell us about your symptom(s) today. Symptom #2

Symptom

Symptom Start Date

☐ Experienced before?

## On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

## What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

## What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

## What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp ☐ Shooting ☐ Stabbing pain ☐ Tightness
☐ Tingling ☐ Throbbing

## What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Occasionally (26 - 50% of the day) ◯ Intermittently (0 - 25% of the day)

## What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing works
☐ Pain Medicines ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy ☐ Other

## What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending ☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs ☐ Concentrating ☐ Cooking/Cleaning
☐ Crouching/Squatting ☐ Doctor's visits ☐ Doing Hobbies ☐ Doing things on time ☐ Dressing ☐ Driving
☐ Eating ☐ Exercise/Sports ☐ Financial Management ☐ Gardening ☐ General Mobility
☐ Getting Places ☐ Hearing ☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance
☐ Knitting ☐ Leaning ☐ Lifting ☐ Light/Sound ☐ Lying down ☐ Making decisions ☐ Moving Joint/s
☐ Mowing ☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Seeing ☐ Sewing ☐ Sexual Activity ☐ Shopping
☐ Sitting ☐ Speaking ☐ Standing ☐ Turning ☐ Twisting ☐ Using the phone ☐ Walking
☐ Watching TV ☐ Working ☐ Yard work

## What are your expectations regarding this symptom?

What are your expectations regarding this symptom? - Continued

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity

If you have additional symptoms to record, please continue on the next page.

## Tell us about your symptom(s) today. Symptom #3

Symptom

Symptom Start Date

☐ Experienced before?

## On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

## What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

## What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

## What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp ☐ Shooting ☐ Stabbing pain ☐ Tightness
☐ Tingling ☐ Throbbing

## What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Occasionally (26 - 50% of the day) ◯ Intermittently (0 - 25% of the day)

## What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing works
☐ Pain Medicines ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy ☐ Other

## What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending ☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs ☐ Concentrating ☐ Cooking/Cleaning
☐ Crouching/Squatting ☐ Doctor's visits ☐ Doing Hobbies ☐ Doing things on time ☐ Dressing ☐ Driving
☐ Eating ☐ Exercise/Sports ☐ Financial Management ☐ Gardening ☐ General Mobility
☐ Getting Places ☐ Hearing ☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance
☐ Knitting ☐ Leaning ☐ Lifting ☐ Light/Sound ☐ Lying down ☐ Making decisions ☐ Moving Joint/s
☐ Mowing ☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Seeing ☐ Sewing ☐ Sexual Activity ☐ Shopping
☐ Sitting ☐ Speaking ☐ Standing ☐ Turning ☐ Twisting ☐ Using the phone ☐ Walking
☐ Watching TV ☐ Working ☐ Yard work

## What are your expectations regarding this symptom?

What are your expectations regarding this symptom? - Continued

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity

If you have additional symptoms to record, please continue on the next page.

## Tell us about your symptom(s) today. Symptom #4

Symptom

Symptom Start Date

☐ Experienced before?

## On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

## What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

## What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

## What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp ☐ Shooting ☐ Stabbing pain ☐ Tightness
☐ Tingling ☐ Throbbing

## What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Occasionally (26 - 50% of the day) ◯ Intermittently (0 - 25% of the day)

## What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing works
☐ Pain Medicines ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy ☐ Other

## What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending ☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs ☐ Concentrating ☐ Cooking/Cleaning
☐ Crouching/Squatting ☐ Doctor's visits ☐ Doing Hobbies ☐ Doing things on time ☐ Dressing ☐ Driving
☐ Eating ☐ Exercise/Sports ☐ Financial Management ☐ Gardening ☐ General Mobility
☐ Getting Places ☐ Hearing ☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance
☐ Knitting ☐ Leaning ☐ Lifting ☐ Light/Sound ☐ Lying down ☐ Making decisions ☐ Moving Joint/s
☐ Mowing ☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Seeing ☐ Sewing ☐ Sexual Activity ☐ Shopping
☐ Sitting ☐ Speaking ☐ Standing ☐ Turning ☐ Twisting ☐ Using the phone ☐ Walking
☐ Watching TV ☐ Working ☐ Yard work

## What are your expectations regarding this symptom?

What are your expectations regarding this symptom? - Continued

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity

If you have additional symptoms to record, please continue on the next page.

## Tell us about your symptom(s) today. Symptom #5

Symptom

Symptom Start Date

☐ Experienced before?

## On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

## What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

## What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

## What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp ☐ Shooting ☐ Stabbing pain ☐ Tightness
☐ Tingling ☐ Throbbing

## What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Occasionally (26 - 50% of the day) ◯ Intermittently (0 - 25% of the day)

## What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing works
☐ Pain Medicines ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy ☐ Other

## What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending ☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs ☐ Concentrating ☐ Cooking/Cleaning
☐ Crouching/Squatting ☐ Doctor's visits ☐ Doing Hobbies ☐ Doing things on time ☐ Dressing ☐ Driving
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☐ Getting Places ☐ Hearing ☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance
☐ Knitting ☐ Leaning ☐ Lifting ☐ Light/Sound ☐ Lying down ☐ Making decisions ☐ Moving Joint/s
☐ Mowing ☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Seeing ☐ Sewing ☐ Sexual Activity ☐ Shopping
☐ Sitting ☐ Speaking ☐ Standing ☐ Turning ☐ Twisting ☐ Using the phone ☐ Walking
☐ Watching TV ☐ Working ☐ Yard work

## What are your expectations regarding this symptom?

What are your expectations regarding this symptom? - Continued

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity