

dba **Smart Pain Solutions**

Clayton Pain Clinic LLC

225 S Meramec Ave #306, Clayton MO 63105

p.314.298.1400 f.314.298.1401

**Patient Intake**

Date: \_\_\_\_\_ E-mail: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS # \_\_\_\_\_ Sex:  Male  Female

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Married  Widowed  Single  Divorced  Minor

Insurance Company Name: \_\_\_\_\_ Health Savings Account:  Yes  No

Secondary Insurance Company Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Have you ever received Chiropractic care?  Yes  No If so, When & Where? \_\_\_\_\_

Have you ever received Physical Therapy services?  Yes  No If so, When & Where? \_\_\_\_\_

**In Case of Emergency Contact:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_) \_\_\_\_\_

**Accident Information**

Is condition due to an accident?  Yes  No Date: \_\_\_\_\_

Type of accident:  Auto  Work  Home  Other: \_\_\_\_\_

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other \_\_\_\_\_

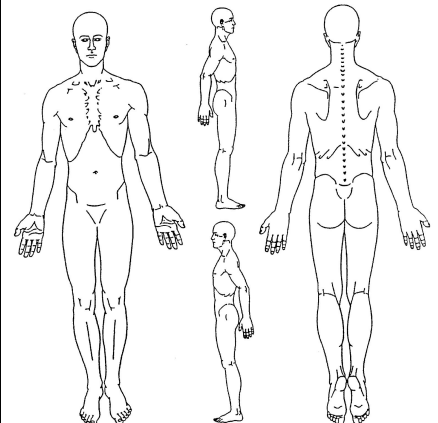
Attorney Name (if applicable): \_\_\_\_\_

Attorney Phone Number: \_\_\_\_\_

**Patient Complaints**

Please List all of the complaints/problems you would like the doctor to look at today. Mark an X on the picture for each problem. Please prioritize them from most important to least important. You will be given complaint forms for each problem listed to more thoroughly describe each problem.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_



Patient Name:

Date:

### Health History

To help us rule out any conditions which might be aggravated by massage, please fill in all the appropriate information.

Are you currently being treated for any medical condition? Medical, chiropractic, physical therapy or other treatment?  No  Yes

If yes, who is treating you, what is/are the condition(s), how long have you been treated and how are you being treated?

Physician	Condition	How Long	Type of Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have a primary care physician?  No  Yes Name: \_\_\_\_\_ Date of Last: \_\_\_\_\_ Physical Exam: \_\_\_\_\_ Spinal Exam: \_\_\_\_\_

Spinal X-ray: \_\_\_\_\_ Chest X-ray: \_\_\_\_\_ MRI, CT, Bone Scan: \_\_\_\_\_  
Blood Test: \_\_\_\_\_ Urine Test: \_\_\_\_\_

Are you Pregnant?  No  Yes Due Date: \_\_\_\_\_

**Please mark on "Yes" or "No" to indicate if you have had any of the following:**

- |  |   |  |   |
|--|---|--|---|
| 1. AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No           | 6. Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No        | 11. Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No     | 16. Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 2. Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No          | 7. Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No       | 12. MS <input type="checkbox"/> Yes <input type="checkbox"/> No            | 17. Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Bleeding disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Gout <input type="checkbox"/> Yes <input type="checkbox"/> No            | 13. Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No  | 18. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| 4. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No             | 9. Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No  | 14. Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No     | 19. Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| 5. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No           | 10. Metal Implants <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No          |

If "Yes", please write the number of the condition and explain when it was diagnosed and how it was treated

#	When you had it	How it was treated	Additional explanation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Habits

- Tobacco  Regularly  Rarely  Never Explain \_\_\_\_\_
- Alcohol  Regularly  Rarely  Never Explain \_\_\_\_\_
- Caffeine  Regularly  Rarely  Never Explain \_\_\_\_\_
- Exercise  Regularly  Rarely  Never Explain \_\_\_\_\_
- High Stress  Regularly  Rarely  Never Explain \_\_\_\_\_

Would you be interested in additional information on any of the following?

- Nutrition  Exercise/Stretching  Work Station  Other \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
<i>Falls</i>	_____	_____
<i>Head injuries</i>	_____	_____
<i>Broken Bones</i>	_____	_____
<i>Dislocations</i>	_____	_____
<i>Surgeries</i>	_____	_____
<i>Car accidents</i>	_____	_____

### Work Activity

What do you do for work: \_\_\_\_\_  
 Sitting  Standing  Computer  Repetitious tasks  
 Lifting  Weird postures  Light labor  Heavy labor

Is your desk set up ergonomically?  No  Yes  
Do you take breaks?  No  Yes  
Is your job stressful?  No  Yes Why? \_\_\_\_\_

### Medications/Supplements

For: \_\_\_\_\_  
For: \_\_\_\_\_  
For: \_\_\_\_\_  
For: \_\_\_\_\_

Allergies: \_\_\_\_\_