

# DiLollo Chiropractic

## CONFIDENTIAL PATIENT INFORMATION (Please Print)

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status    M    S    W    D                      # of Children \_\_\_\_\_

Your Occupation / Position \_\_\_\_\_

Name of Spouse / Guardian-Occupation / Position \_\_\_\_\_

Email Address \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

List your problems / complaints according to severity	Date started or for how long	If you had the condition before, when?	Did problem begin with injury? Date
1.			
2.			
3.			
4.			

Is this condition interfering with you is: ( ) Work Sleep ( ) Daily Routine ( ) Sports/Exercise ( ) Other \_\_\_\_\_

What aggravates your condition most? \_\_\_\_\_

Have you seen any other Doctors for this condition? \_\_\_\_\_

If yes, who? ( ) Medical Doctor ( ) Chiropractor ( ) Dentist ( ) Other \_\_\_\_\_

1. Name \_\_\_\_\_ Address \_\_\_\_\_

When? \_\_\_\_\_ What did Dr. say was wrong? \_\_\_\_\_

2. Name \_\_\_\_\_ Address \_\_\_\_\_

When? \_\_\_\_\_ What did Dr. say was wrong? \_\_\_\_\_

3. Name \_\_\_\_\_ Address \_\_\_\_\_

When? \_\_\_\_\_ What did Dr. say was wrong? \_\_\_\_\_

List any medications (drugs) you are taking: \_\_\_\_\_

Have you had any x-rays taken?    When? \_\_\_\_\_    Where? \_\_\_\_\_    Area of Body \_\_\_\_\_

When? \_\_\_\_\_    Where? \_\_\_\_\_    Area of Body \_\_\_\_\_

Accidents and/or injuries: Auto, Work Related or Other (especially those related to your present problem)

1. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No  
2. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No  
3. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No

NOTE: If you have RECENTLY been involved in an accident or injury, please inform a staff member so they may prepare the proper forms.

Have you had any surgery? (Please include all surgeries)

1. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No  
2. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No  
3. Type \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized ( ) Yes ( ) No

Please check all symptoms you have, even if they do not seem related to your visit to this office.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness                 | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Allergies       |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats              | <input type="checkbox"/> Light bothers eyes       | <input type="checkbox"/> Problems urinating     | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Menstrual pain           | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Emphysema       |
| <input type="checkbox"/> Epilepsy / Seizures      | <input type="checkbox"/> Miscarriage              | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Thyroid condition      | <input type="checkbox"/> Infertility     |

Have you ever tried chiropractic before? ( ) Yes ( ) No Was the experience ( ) positive or ( ) negative?

Do you take vitamins? ( ) Yes ( ) No If yes, how long? \_\_\_\_\_

Do/did you smoke tobacco? ( ) Yes ( ) No If yes, how long? \_\_\_\_\_

Were you vaccinated? ( ) Yes ( ) No ( ) Unsure

Are you pregnant? ( ) Yes ( ) No If yes, how many weeks? \_\_\_\_\_

On a scale of 1-10, describe your stress levels (1=none, 10=extreme): Home/Personal \_\_\_\_\_ Work \_\_\_\_\_

On a scale of excellent, good or poor, describe how well you:

Eat \_\_\_\_\_ Drink \_\_\_\_\_ Breathe \_\_\_\_\_ Think \_\_\_\_\_ Rest \_\_\_\_\_ Exercise \_\_\_\_\_

On a scale of 1-10, 10 being the highest, rate your commitment to getting rid of these problems: \_\_\_\_\_

If you have children, do they have earaches, allergies, colds, headaches or other problems? \_\_\_\_\_

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made.

Your cooperation is expected and appreciated.

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

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_

Date: \_\_\_\_\_