D'Angiolillo Chiropractic Center

Helping all ages reach their maximum health potential

Patient's Name:_____ Social Security Number:_____

Address:_____ Town:_____ State_____ Zip:_____

Home Telephone:_____ Cell Phone: _____ E-mail Address:_____

Sex: M F Age:_____ Birthdate:_____ Marital Status: M S W D Spouse's Name:_____

Work Address & Telephone :_____

Occupation:_____ How Were You Referred To This Office:_____

Have you ever had previous chiropractic care?_____ If so, why?_____

Previous Chiropractor's Name:_____ When consulted:_____

Reason for consulting this office:

- ☐ Disease, symptoms or infirmities
- ☐ Preventing disease, symptoms or infirmities
- ☐ Maximizing personal health potentials
- ☐ Improving family and/or community health

What is your major complaint?_____

_____

Other Complaints:_____

_____

How long have you had this condition?_____ Have you had similar conditions in the past?_____

Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other_____

How long has it been since you really felt good?_____

What activities aggravate your condition?_____

What make your condition better?_____

Have other doctors been seen for this condition? ☐ Yes ☐ No

If Yes, The Name of the physician:_____ and treatment given:_____

List of any surgical procedures you have had and the years:_____

_____

List drugs you now take:_____

_____

Name of family physician:_____ Are you happy? ☐ Yes ☐ No

Date of last visit:_____ Purpose:_____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports ☐ Inner soles

Age of your mattress:_____ ☐ Comforable ☐ Uncomfortable

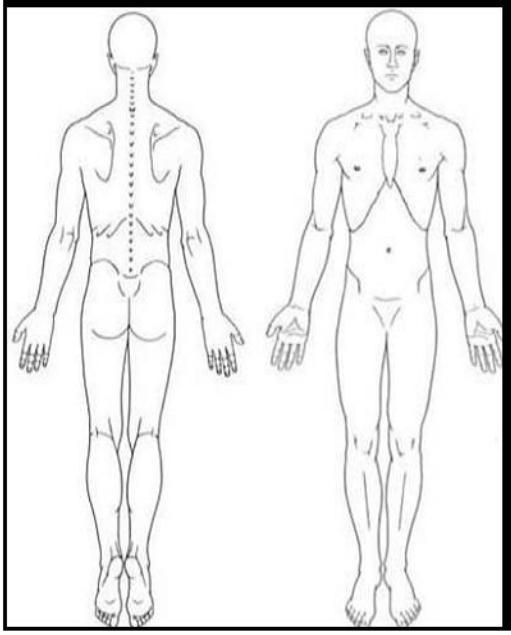
Have you ever been in an auto accident? ☐ Past year ☐ past 5 years ☐ over 5 years ☐ never

Have you ever had a personal injury? ☐ Past year ☐ past 5 years ☐ over 5 years ☐ never

Describe:_____

_____

Please mark the areas of pain numbness, tingling



Below is a listing of symptoms, conditions, or habits. Please check the box indicating whether this applies to your past or present health.

	Past	Present		Past	Present
Neck pain	___	___	High blood pressure	___	___
Shoulder pain	___	___	Heart condition	___	___
Arm/elbow pain	___	___	Respiratory condition	___	___
Hand pain	___	___	Digestive problems	___	___
Upper back pain	___	___	Kidney/bladder problems	___	___
Lower back Pain	___	___	Menstrual problems	___	___
Pain in upper leg or hip	___	___	Breast soreness/lumps	___	___
Pain in lower leg or knee	___	___	Sinus conditions	___	___
Pain in ankle or foot	___	___	Allergies or asthma	___	___
Jaw pain	___	___	Cancer	___	___
Swelling/stiffness of joints	___	___	Stroke	___	___
Headaches	___	___	Excessive weight loss/gain	___	___
Dizziness	___	___	Skin conditions	___	___
Fainting spells	___	___	Arthritis	___	___
Convulsions	___	___	Diabetes	___	___
General prolonged fatigue	___	___	Prostate condition	___	___
Condition of the ovaries	___	___	Condition of the uterus	___	___

Comments:_____

Tobacco Use: ☐ Past ☐ Present ☐ Occassional ☐ Moderate ☐ Heavy ☐ Never

Alcohol Use: ☐ Past ☐ Present ☐ Occassional ☐ Moderate ☐ Heavy ☐ Never

Caffeine Use: ☐ Past ☐ Present ☐ Occassional ☐ Moderate ☐ Heavy ☐ Never

Pregnancy: ☐ Past ☐ Present Number of pregnancies:_____ ☐ Never

Insurance Information:

Is your condition due to an auto accident or job injury? ____ Yes ____ No

Do You have health insurance? ____ Yes ____ No

If Yes

Name of Company:_____ Policy No:_____

Insured's Name:_____ Social Security No:_____

Insured's Date of Birth:_____ Employer:_____

Relation to Insured: ____ Self ____ Spouse ____ Child ____ Other

Do You Have Medicare? ___ Yes ___ No

If Yes

Medicare No:_____

I understand and agree that health insurance and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from an insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable.

Original x-rays and records remain the property of this office.

Patient's Signature:_____ Date:_____

Guardian or Spouse's Signature:_____ Date:_____