DiLollo Chiropractic

CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Full Name _____ Date _____

Address _____ City, State, Zip _____

Home Telephone # _____ Cell Telephone # _____

Work Telephone _____ 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 your: ( ) Work/Sleep ( ) Daily Routine ( ) Sports/Exercise ( ) Other_____

What aggravates your condition most? _____

Have you seen any other Doctors/Practitioners for this condition? _____

If yes, who? ( ) Medical Doctor ( ) Chiropractor ( ) Dentist ( ) Other_____

1. When? _____ What did Dr. say was wrong? _____
2. When? _____ What did Dr. say was wrong? _____

List any medications(drugs) you are taking: _____ Reason _____ How Long _____
_____ Reason _____ How Long _____
_____ Reason _____ How Long _____
_____ Reason _____ How Long _____

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)

If yes, do you have any metal/screws in your body? _____ Where? _____

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.

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

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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: _____

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:_____