Doinidis Chiropractic Health Center

Name_____Sex M F Date_____

Address_____City_____State_____Zip_____

H. Phone (_____)_____Cell Phone_____ Date of Birth_____ Age_____

Referred by_____ Emergency Contact _____Phone_____

Occupation_____ Employer_____

Marital Status S M W D Number of children_____ Email_____

Do you have an HSA or FSA through work? _____

Name of insurance company _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Chief Complaints: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) **0 1 2 3 4 5 6 7 8 9 10** (Worst possible pain/complaint imaginable)

How frequent is your complaint and how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury, trauma, falls or accidents? _____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

(TURN OVER)

Patient #_____

D. Medications:
Medication & Duration

_____ _____

_____ _____

_____ _____

_____ _____

E. Surgeries:
Date & Type of Surgeries

_____ _____

_____ _____

Please check any of the following that give you difficulty:

[ ] Headaches	[ ] Fainting	[ ] Heart Attacks	[ ] Numbness
[ ] Shooting head pains	[ ] Loss of balance	[ ] High blood pressure	[ ] Constipation
[ ] Sinus trouble	[ ] Ringing in ears	[ ] Low blood pressure	[ ] Kidney trouble
[ ] Loss of smell	[ ] Blurred vision	[ ] Anemia	[ ] Menstrual cramps and pain
[ ] Allergies	[ ] Light bother eyes	[ ] Stomach trouble	[ ] Menstrual irregularity
[ ] Hay fever	[ ] Neck pain	[ ] Nerves and nervousness	[ ] Diabetes
[ ] Asthma	[ ] Muscle spasms in neck	[ ] Inner tension	[ ] Cancer
[ ] Loss of taste	[ ] Grating in neck	[ ] Irritability	[ ] Sleeping problems
[ ] Tightness of throat	[ ] Tightness in shoulder muscle	[ ] Cold sweats	[ ] Painful joints
[ ] Inflammation of throat	[ ] Pain in shoulders and arms	[ ] Gall bladder problems	[ ] Swollen joints
[ ] Thyroid trouble	[ ] Pins and needles in arms/hands	[ ] Indigestion	[ ] Pinched nerves in back/neck
[ ] Twitching in face	[ ] Cold hands	[ ] Intestinal gas	[ ] Pins and needles in legs
[ ] Loss of memory	[ ] Chest pains	[ ] Low back pain	[ ] Swollen ankles
[ ] Fatigue	[ ] Shortness of breath	[ ] Dizziness	[ ] Cold feet
[ ] Depression	[ ] Mid-back pain		[ ] Pains in legs and feet

F. Females: Is there a possibility that you are pregnant? **Yes** **No**

3. Family Health History:

Health problems of relatives: _____

_____

_____

4. Social and Occupational History:

A. Job description: _____

B. Do you exercise? **Yes** **No** **Type** _____ **Frequency** _____

C. Alcohol & Tobacco Use? **Yes** **No** **Frequency** _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Doinidis Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____