DONNELLY CHIROPRACTIC

PERSONAL HISTORY

DATE: _____ **PATIENT NAME:** _____ **DOB:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE: HOME _____ **CELL** _____ **WORK** _____

EMAIL ADDRESS: _____ **TEXT ALERTS?** Y / N

SS#: _____ **AGE:** _____ **GENDER:** M / F **MARITAL STATUS:** ☐ Single ☐ Married ☐ Widowed ☐ Other

ETHNICITY / RACE: _____ **LANGUAGE(S):** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

HOW DID YOU HEAR ABOUT US? ☐ Google ☐ Yelp ☐ Facebook ☐ Friend/Family/Coworker _____ ☐ Other: _____

WHO IS RESPONSIBLE FOR YOUR BILL? ☐ Self ☐ PI Lawyer ☐ Auto Insurance ☐ Workers Comp ☐ Medicare ☐ Personal Insurance

CURRENT MEDICAL

PLEASE LIST ALL CURRENT VITAMINS, SUPPLEMENTS AND MEDICATIONS BELOW:

PRODUCT NAME	REASON	START DATE
1.		
2.		
3.		
4.		
5.		
6.		

Please list all known Allergies: _____

Have you been treated for any other health conditions in the last year? ☐ Yes ☐ No

If Yes, please list: _____

Purpose for this appointment: _____

When did it begin? Please give a date: _____

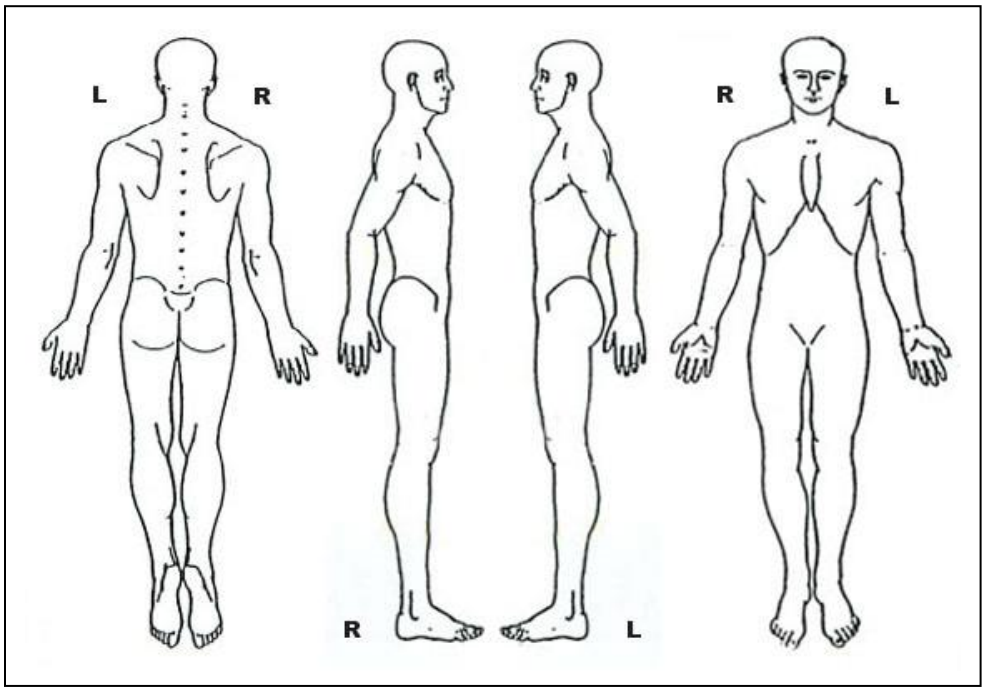
Frequency of the pain: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

When is it the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ during the Night

Rate the pain: (circle one)

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Have you seen a Chiropractor in the past? ☐ Yes ☐ No If so, when was your last visit? _____



PLEASE MARK THE DRAWING AS FOLLOWS:

A = ACHY
B = BURNING
D = DULL
SH = SHARP
ST = STIFF
TH = THROBBING
TI = TINGLING
O = OTHER

IF OTHER, PLEASE EXPLAIN:

_____
_____
_____
_____

PAST MEDICAL CONDITIONS

PREVIOUS INJURIES

Date: _____ Area of Injury: _____ Description: _____

Date: _____ Area of Injury: _____ Description: _____

PREVIOUS SURGERIES OR HOSPITALIZATIONS

Date: _____ Reason: _____ Result: _____

Date: _____ Reason: _____ Result: _____

Date: _____ Reason: _____ Result: _____

LIFESTYLE HISTORY

Do you smoke cigarettes, cigars, or chew tobacco? ☐ Yes ☐ No How many years? _____ Quit date: _____

☐ Light (< 1 pack a week) ☐ Moderate (< 1 pack a day) ☐ Heavy (> 1 pack a day)

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Daily ☐ Former alcoholic

What is your activity level? ☐ Sedentary (no exercise) ☐ Light (Non-aerobic: yoga, walking, treadmill, etc.)

☐ Moderate (aerobic, jogging, weight-lifting, etc.) ☐ Vigorous (HIIT, plyometrics)

How many hours of sleep do you average a night? _____ Hours

What is your daily intake of Water? ☐ 0 glasses ☐ 1-3 glasses ☐ 4-6 glasses ☐ 7 + glasses

How many caffeinated beverages do you drink daily? ☐ None ☐ 1-3 ☐ 3-6 ☐ 6 +

Do you regularly consume: ☐ Refined sugars (White sugar, sweets) ☐ Wheat products (Pasta, bread, cereal) ☐ Dairy products

FAMILY HISTORY

Please list medical conditions such as Heart Disease, High Blood Pressure, Stroke, Cancer, Diabetes or Thyroid:

Mother: _____

Father: _____

Brother: _____

Sister: _____

Maternal grandmother: _____

Maternal grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

OTHER

ANYTHING ELSE YOU FEEL THE DOCTOR SHOULD KNOW: _____

_____

_____

I understand the information within this form and guarantee that it is correct to the best of my knowledge.

_____ _____

Signature Date