SIGILLO CHIROPRACTIC PC

Please complete this confidential questionnaire.

Date: _____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Date of Birth _____ Gender: Male Female

Martial Status: Married Divorced Single Widow Partner

Employer & Occupation _____

Spouses/Partners Name _____

Who referred you to our office? _____

In case of emergency who do you want us to contact

Name _____ Phone _____

Health Informantion:

Patient Height _____ Weight _____

Smoking Status: Everyday Smoker Sometime Smoker Former Smoker Never Smoked

Is this injury the result of a work related incident or car accident? Yes No

What is your primary reason for coming to the office? _____

Does the pain radiate anywhere? _____

How and when did it start? _____

Have you had prior symptoms in the area? Yes No

What makes symptoms better? _____ Worse _____

How would you describe your pain? _____

Is condition getting : Better Worse Stays the same Comes and Goes

Who is your medical doctor? _____

Have you seen him/her for this condition? Yes No

Have you missed work due to this problem? Yes No

Have you been treated by a chiropractor before? Yes No

If yes, who was the chiropractor? _____

Have you had X-rays taken previously for this problem? Yes No

If yes, where were the X-rays taken? _____

Have you ever had surgery? Yes No If yes, When_____

Have you ever experienced injuries from falls, accidents or sports? _____

Any additional information the doctor should know: _____

_____

Please list all medications you are taking: _____

_____

Please list any Allergies:_____

Circle if you have or have ever had

General:	Allergies	Convulsions	Depression	Dizziness	Fainting
	Fatigue	Headaches	Loss of sleep	Loss of weight	Nervousness
	Numbness				
Muscle & Joints:	Arthritis	Bursitis	Cramps	Hernia	Low back pain
	Mid back pain	Neck pain	Poor Posture	Sciatica	Spinal curvature
	Tail bone pain				
	Do you have numbness in:		Arms or Hands	Shoulders	Legs or Feet
Gastrointestirial:	Constipation	Diarrhea	Gall Bladder	Hemorrhoids	Liver
	Nausea	Stomach			
Ears, Nose, Eye, Etc:	Asthma	Deafness	Earache	Ear noises	Eye Pain
	Failing Vision	Thyroid Problems			
Cardiovascular:	Chest pain	Hardening of arteriers	High Blood Pressure	Low Blood Pressure	Poor circulation
	Rapid heart beat	Slow heart beat	Swelling of ankles		
Respiratory:	Chest pain	Chronic cough	Difficulty breathing	Wheezing	Spitting up blood or phlegm
Genito-Urinary:	Bed-wetting	Blood in urine	Frequent urinination	Painful urinantion	Prostate problems
	Kidney stones/infection				
Women Only:	Cramps	Excessive Bleeding	Painful menstruation		

Are you pregnant? Yes No If yes, due date: _____

If you've had any of the following please circle and date when diagnosised

Alcoholism	Amenia	Appendicitis	Arteriosclerosis	Cancer
Diabetes	Emphysema	Epilepsy	Fibromyalgia	Gout
Lupus	Multiple Sclerosis	Pleurisy	Polio	Tuberculosis