Parlopino
chiropractic

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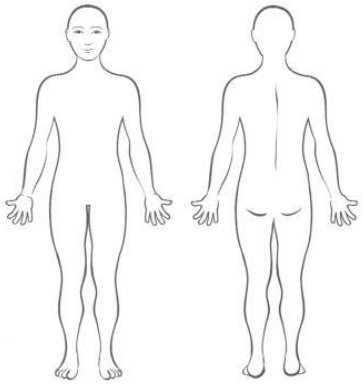
PATIENT HISTORY FORM

Patient Name: _____ Birthdate: _____
Social Security Number: _____ Sex: M/F Height: _____ Weight: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Occupation: _____
Email: _____
How did you hear about us? ___Social Media ___Google Search ___Referral ___Other: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN

___Headache ___Neck Pain ___Mid-back Pain ___ Low Back Pain
___Other: _____
Is this: ___Work Related ___Auto Related ___N/A
Date Problem Began: _____
How Problem Began: _____
How you feel today 0-10, 10 being the worst: _____
How you feel at your worst, 1-10: _____
How you feel at your best, 1-10: _____
How often are your symptoms present?
____0-25% ___26-50% ___51-75% ___76-100% (Constant Pain)



In general, how would you say your health right now is:
___Excellent ___Very Good ___Good ___Fair ___Poor
Have you had a X-Ray, MRI or CT Scan for your area of complaint? ___No ___Yes
Date(s) Taken? _____ What areas were taken? _____

Please check all of the following that apply to you:

____Alcohol/Drug Dependence
____Recent Fever
____Diabetes
____High Blood Pressure
____Corticosteroid Use
____Taking Birth Control Pills
____Dizziness/Fainting
____Numbness in Groin/Buttocks
____Cancer/Tumor
____Osteoporosis
____Epilepsy/Seizures
____Other Health Problems
Explain_____

____Prostate Problems
____Menstrual Problems
____Urinary Problems
____Currently Pregnant, # Weeks_____
____Abnormal Weight: ___Gain ___Loss
____ Marked Morning Pain/Stiffness
____ Pain Unrelieved by Position or Rest
____ Pain at Night
____Visual Disturbances
___ Surgeries: _____
____Tobacco Use-Type _____
Frequency_____/Day

Family History: ___Cancer ___Heart Problems ___Stroke ___Diabetes ___High Blood Pressure ___Arthritis

I certify to the best of my knowledge; the above information is complete and accurate. I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my primary care physician if my condition needs to be co-managed. Therefore, I give authorization to contact my physician if necessary.

Patient Signature_____ Date_____