Daly Chiropractic and Wellness Center

Name: ____ Date: ________________________________ Time: ____________

Birthdate: ____________________ Height: _____________ Weight: ____

Email: ____ Male: ___ Female: ___ Married – Single – Divorced – Widow

Home#: ______________________________ Cell#: ____________________________ Work #: __________________________

Address: ____

Employer: _________________________________ Occupation: ____

Spouse or Guardian: ________________________ Spouse Employer: ____

Emergency Contact: ________________________ Phone#: ____

In the case of a medical emergency, if the patient is of school age 15, the below indicates my consent to treat my child/dependent in my absence.

Parent or Guardian Signature: ____ Date: _____________________________

Do you have any Medical Insurance? Yes No If yes, complete the following:

Name of insured: ____ Relationship to patient: _____________________

SSN#: ________________________________ DOB: __________________ Employer: __________________________________

Employer address: ____

Insurance Company: ________________________ Group#: ____________________ Union or local: ___________________

Automobile Accident: Yes No If yes, date: ___________ Claim#: ____

History of Present Illness

Complaint/s : (Reason for Visit) ____

____

____

Onset: ____________________ Pain: • minimal •Moderate •Severe

What activities have you given up or changed due to this issue? **Circle all that apply**

- Playing with kids or pets
- Enjoying time with friends
- Sports: golf, tennis, pickleball, weightlifting, running, biking, other____
- Household chores
- Travel / driving
- Sleep
- Other: ____

Have you ever had this in the past? Yes No When?: ____
What makes it **better**? ____
What makes it **worse**? ____
Are you?: • getting worse • constant • comes and goes
Have you seen another doctor or received treatment for this condition? Yes No
If so, who and what treatment? ____

Medications/Herbs/Vitamins **you are currently taking:**

List Surgeries/Operations you have had and dates:

Date of you last physical examination? ____

Medical History: (Do you have or have you ever had): **Circle all that apply**

• Arthritis • Asthma • Anemia • Heart trouble • Cancer • Diabetes • Epilepsy • Stroke • Kidney or bladder trouble
• Gallstones • Ulcers • High blood pressure • Chronic fatigue • Hepatitis • Jaundice • Sudden weight loss or gain

Family History: (Has any family member had any of the above)? Yes No If yes, please list below
____
____

Energy Level: • High (time of the day) ________________________ • Low (time of the day) ____________________

Stress: • None • Moderate • Severe What causes stress? ______________________________
____

Circle all that apply:

Sweating: • Night sweats • Rarely sweat • Excessive sweating
Circulation: •Cold hands / feet•Bleed easily • Feeling of hot or cold What area? _______________________
Skin: •Dry •Itcy •Moist/Clammy •Burning •Changing moles, lumbs, cysts •Boils •Rashes •Acne •Hair loss/thinning
• Dry scalp • Puffy skin/wrinkled •Hives • Bruise easy
Sleep: •Touble falling asleep • Trouble staying asleep •Restfull leg syndrome •Restfull sleep
What time do you go to bed? ____________________ What time do you get up? __________________

Patient Name ____

Daly Chiropractic and Wellness Center

Head: •Headaches (what area?) ______________________ • Dizziness • Memory loss • Loss of balance

Eyes: •Pain •Dry • Blurred vision • Darkness under eyes •Watery • Other __________________________

Ears: •Poor hearing •Earaches • Discharge/infections • Ringing/buzzing

Nose: • Nose bleeds • Sinus congestion •Snoring • Frequent colds • Other __________________________

Throat: • Sore throat •Hoarseness • Difficult swallowing • Jaw pain/TMJ • Teeth/gum pain • swollen tongue • Other ____

Chest: • Hard to breathe •Whezzing • Shortness of breath • Mucus rattles when breathing • Palpitations •Trouble breathing at night • Pain/Pressure in chest •Persistantcough • Coughing blood/phlegm

Blood Pressure: • High • Low • Normal

Bowels: • Diarrhea •Constipation • Bloody stools • Black stools • Mucus in stool •Hemorrhoids • Gas • Colon problems • Number of bowel movements per day ____________________________________ Have you been diagnosed with any digestion issues? ____

Joints: **Pain in**: • Neck • Mid back • Lower back • Arms/hands •Hips •Knee •Shoulders • Elbows • Feet
Other: ____

Neurological: •Nervousness •Depressed • Angered easy • Irritated easy • Frequent crying •Suicidal • Worry • Anxiety • Mood swings • Memory loss • Confusion • Poor Concentration • Tremors • Seizures • Numbness Limbs • Poor coordination • Muscle weakness • Feeling Shakey

Females:•Pregnant? Yes No • Low sex drive • Hot flashes

Males: • Erectile dysfunction • Low sex drive • Prostate issues • Hard to evacuate fully

Appetitie: • Excessive •Poor • Special dietary habits? ____

Digestion: • Gas after meal • Acid Reflux •Heartburn •Bloating • Weight gain • Weight loss (unexpected)

Nutrition: • How many meals a day to you eat? ______ •Water intake? ___ oz/day • Soda intake?___________/day • Do you smoke? Yes No Years______ • Special diet? ____

Is there anything else that you would like to discuss?

____

____

____

____

Thank you for choosing our office.

Patient Signature: ____ Date: _____________________

Provider: _________________________ Signature: _____________________________ Date: _____________________

Patient Name ____