



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: _____

REFERRED TO US BY? _____

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

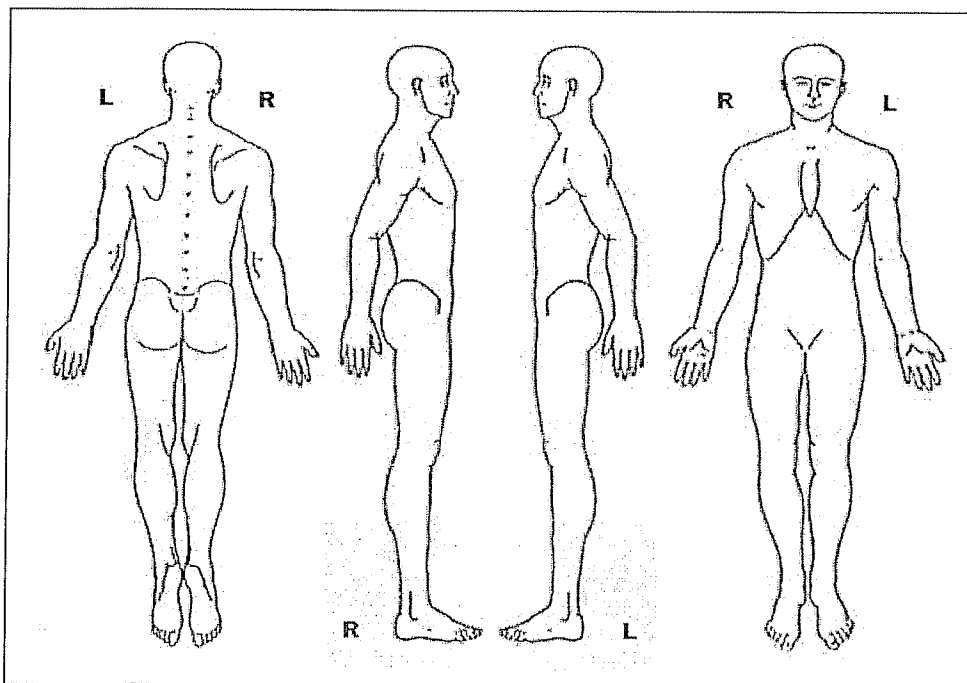
Frequency of the pain: Constant Frequent Intermittent Occasional

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 Wheat products Dairy products
(White sugar, sweets) (Pasta, bread, cereal)

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