SANFILIPO CHIROPRACTIC
ORTHOPEDICS & REHAB

PERSONAL DATA

Date _____ Patient's Social Security No. _____

Patient's Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Phones: Home _____ Cell _____

Work _____ Email _____

Check if you are: ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated

Name of Spouse _____ Spouse's Date of Birth _____

Employer _____ Spouse's Employer _____

If under 18, Parent/Legal Guardian Name _____

Parent/Guardian's Signature for Consent to Treat _____

Referred to this Office by _____

Primary Care Provider _____ Date of Last Visit _____

Address _____ City/State/Zip _____

PLEASE CHECK TYPE OF INSURANCE YOU HAVE

___ CIGNA #_____

___ BCBS #_____

___ EXCELLUS #_____

___ MEDICARE BLUE CHOICE #_____

___ AETNA #_____

___ UNITED HEALTHCARE #_____

___ MVP # _____

___ NYS NO FAULT # _____

___ MEDICARE # _____

___ WORKERS COMP #_____

___ OTHER _____

_____

MEDICAL HISTORY ~ GENERAL DATA

Height _____ Weight _____ ___ Right Handed ___ Left Handed

Occupation - Describe your activities at work

___ Assembly / Factory

___ Construction

___ Heavy repetitive bending / lifting

___ Clerical / Desk work

___ Computers

___ Other _____

When did pain first occur? _____

How did it happen? _____

Have you had this problem before? _____

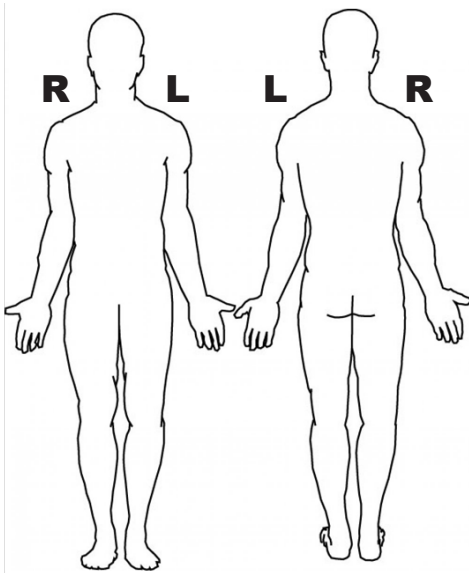
Is this work related? ___ Yes ___ No Motor vehicle related? ___ Yes ___ No

DESCRIBE PAIN:

___ Sharp / Stabbing
___ Pins & Needles
___ Stiff
___ Ache
___ Burning
___ Throbbing
___ Numbness
___ Other _____

Mark All Areas Where You Feel Pain On Body Using The Key Below

Stabbing	/ / / /
Pins/Needles	0000
Numbness	====
Burning	xxxx
Ache:	####
Other	*****



Rate your pain right now on a scale of 1-10:

___ 0 (No pain) ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 (Excruciating Pain)

At best this past week:

___ 0 (No pain) ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 (Excruciating Pain)

At worst this past week:

___ 0 (No pain) ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 (Excruciating Pain)

Does the pain radiate? If so, where? _____

Does it hurt more in: ___ Morning ___ Afternoon ___ Evening ___ Constantly ___ Disturbs sleep

Does it hurt to cough or sneeze? ___ Yes ___ No

Have you missed time from work? ___ Yes ___ No If Yes, last day worked _____

Are you working with any restrictions? ___ Yes ___ No If Yes, what are they? _____

What activities are you unable to do? At home _____

At work _____

For this condition, have you had

___ X-Rays ___ CT Scan ___ MRI ___ Bone Scan ___ Electro Diag. Study ___ Other

List medications: _____

Date of last complete exam: _____

Do you excercise regularly? ___ Yes ___ No If Yes, what do you do? _____

_____ How often? _____

Which of the following aggravates your condition? ___ Sitting down ___ Sitting for long periods

___ Standing ___ Standing for long periods ___ Walking ___ Lying down ___ Body movement

___ Deep breathing ___ Sleeping

Specific movements _____

Other _____

Which of the following relieves your condition? ___ Sitting down ___ Moist Heat / Hot Shower

___ Walking ___ Lying down ___ Massage ___ Ice ___ Sleeping ___ Exercise ___ Stretching

___ Other: _____

___ Medications: _____

Is your condition ___ Getting worse ___ Getting better ___ Constant ___ Coming & Going

Which of the following professionals have you sought treatment for your condition?

___ Family physician ___ Neurologist ___ Neurosurgeon ___ Psychiatrist ___ Chiropractor

___ Physical Therapist ___ Massage Therapist ___ Accupuncturist ___ Epidural/Nerve Block

___ Orthopedist / Orthopedic Surgeon ___ Other _____

Please describe what treatment, if any, provided relief for this condition & how long did it last _____

_____

Are you taking blood thinner agents? ___ Yes ___ No

PREVIOUS SURGERIES / HOSPITALIZATIONS

1. Reason: _____ Date: _____
2. Reason: _____ Date: _____
3. Reason: _____ Date: _____
4. Reason: _____ Date: _____

PREVIOUS ORTHOPEDIC PROBLEM

Arthritis Where: _____ Date: _____

Torn Ligaments / Tendonitis / Bursitis Where: _____ Date: _____

Fractures Where: _____ Date: _____

Extremities (Schoulder, Elbow, Knee, Hip, etc.) Where: _____ Date: _____

Accidents (MVA's, WCB, Falls etc.) Where: _____

FAMILY HISTORY

Father: Age _____ Alive ___ Deceased ___ Illness/Cause of death _____

Mother: Age _____ Alive ___ Deceased ___ Illness/Cause of death _____

Number of Brothers _____ Serious illness, if any _____

Number of Sisters _____ Serious illness, if any _____

Any other family members with similar condition _____

PERSONAL HISTORY

Smoker? ___Yes ___ No # daily ___ Age started ___ Date Quit _____ Would you like to quit? _____

Alcohol Consumption ___ Yes ___ No Times per week ___

Caffein Consumption ___ Yes ___ No Cups per day ___

Substance Abuse ___ Yes ___ No Description _____

MEDICAL HISTORY

General Symptoms ___ Recent weight loss/gain ___ Blurred vision ___ Headache ___ Fainting
___ Loss of sleep ___ Nervousness ___ Fatique ___ Dizziness
___ Other _____

Endocrine ___ Diabetes ___ Parathyroid ___ Gout ___ Liver ___ Thyroid ___ Pituitary ___ Other

Have you ever been prescribed Prednisone? ___ Yes ___ No

HEENT
___ Head injuries ___ Hearing problems
___ Jaw / TMJ problems ___ Inability to taste
___ Eye / Vision problems ___ Inability to smell
___ Difficulty swallowing ___ Difficulty with speech
___ Other _____

Cardiovascular
___ Rapid heartbeat ___ Blood pressure problems
___ Slow heartbeat ___ Poor circulation
___ Stroke ___ Heart attack
___ Irregular heartbeat ___ Varicose veins
___ Ankle / leg swelling ___ Other _____

Pulmonary
___ Asthma ___ Shortness of breath
___ Chronic Bronchitis ___ Other _____

Gastrointestinal
___ Ulcers ___ Hiatal hernia
___ Colitis ___ Gall bladder trouble
___ Diverticulitis ___ Other _____

Genitourinary
___ Kidney stones/infections ___ Bloody urine
___ Painful urination ___ Bladder infection
___ Prostate/Testicle problems ___ Uterine/Ovarian problems
___ Other _____

Neurology/Emotional
___ Depression ___ Anxiety
___ Pinched nerves ___ Other _____

Skin
___ Rashes ___ Psoriasis
___ Moles ___ Other _____

Allergy/Immunology
___ General allergies ___ Anemia
___ Allergies to medication _____
___ Cancer Type _____ Where _____

Have you ever needed to see a doctor for any additional medical problems? Please list:

_____

_____

_____