WELCOME TO UPPER CERVICAL STRONGSVILLE

Anthony Fiorini, DC, LLC

Name:_____Date: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____E-mail: _____

Birth date: _____ Age: _____ Male/ Female

Primary Care Physician Name: _____

Emergency Contact Person: _____ Phone: _____

How did you hear about us or who referred you?_____

Reason for seeking chiropractic care?_____

Health History

In order of importance, describe any health problems including how long you have had them:

1. _____
2. _____
3. _____
4. _____

When was the first time you noticed this problem(s)?_____

Please describe how this problem interferes with your work and/or personal life:

Home activities affected: _____

Work activities affected: _____

Recreational activities affected: _____

Rest or Sleep affected: _____

What has this problem(s) been keeping you from doing that you really like to do?_____

_____

Are you under the care of any other doctor? **Y N** If yes, the conditions being treated for:

_____

_____

Have your health problems been: **Improving** **Worsening** **Staying the same**

Please describe anything you do that improves your condition, or worsens it:_____

_____

List any current medications: _____

List any current vitamins or supplements: _____

List any past surgeries and dates: _____

List any past accidents or injuries and dates: _____

Personal and Family History

Occupation:_____Employer's Name & Address:_____

Work Phone: _____Ext: _____Work Duties: _____

Marital Status: S M W D

Spouse's Name: _____

Women: Are you pregnant? Yes No

Chiropractic History

Have you ever been to a chiropractor before? Y / N If yes, Doctor's name:_____

Date of last chiropractic visit: _____Reason for care:_____

Date of last chiropractic x-rays: _____ How long were you under care?_____

Do you have a wellness practitioner?

What are you doing to keep yourself healthy? _____

SIGNATURE _____ Date: _____

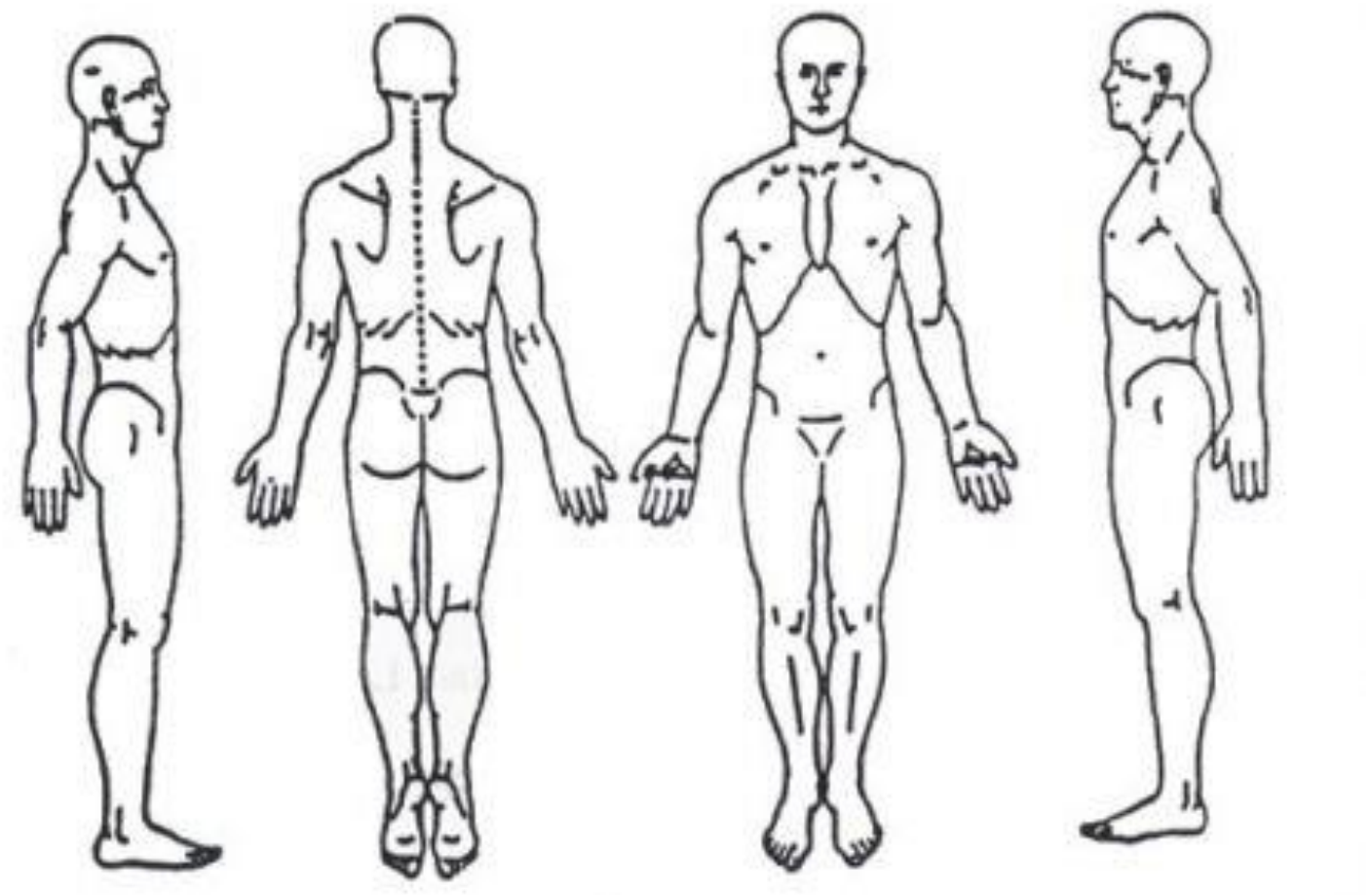
Pain Drawing

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & needles	Burning	Stabbing	Other
++++	= = =	O O O	x x x	/ //	. . . .

RIGHT SIDE **BACK** **FRONT** **LEFT SIDE**



0 = absolutely pain free **10 = worst pain**

0 1 2 3 4 5 6 7 8 9 10