MINICUCCI CHIROPRACTIC, P.C.
TOTAL HEALTH CONCEPTS

PATIENT INFORMATION

Today's Date _____

Name _____

Age _____ DOB _____ Sex ☐ M ☐ F

Address _____

Phone Home _____

Work _____ Cell _____

Cell Carrier _____

Email _____

I consent to receive appointment reminders and office communications by text, email, or telephone. _____ (Initial)

Employer _____

Occupation _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other

Name of Spouse or Nearest Relative _____

Phone: Work _____ Cell _____

Referred to this office by: ☐ Website ☐ Yellow Pages ☐ Friend/Family Member - Name _____

Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐ Automobile Insurance

Are you covered by more than one insurance company? ☐ No ☐ Yes - Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by the above by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
☐	☐	☐	Anemia	☐	☐	☐	Arthritis	☐	☐	☐	Asthma
☐	☐	☐	Back Pain	☐	☐	☐	Bladder Trouble	☐	☐	☐	Bone Fracture
☐	☐	☐	Cancer	☐	☐	☐	Chest Pain	☐	☐	☐	Concussion
☐	☐	☐	Convulsions	☐	☐	☐	Diabetes	☐	☐	☐	Indigestion
☐	☐	☐	Dislocated Joints	☐	☐	☐	Epilepsy	☐	☐	☐	German Measles
☐	☐	☐	Headaches	☐	☐	☐	Heart Trouble	☐	☐	☐	Reproductive Disorders
☐	☐	☐	High Blood Pressure	☐	☐	☐	Kidney Disorder	☐	☐	☐	Bowel Control Loss
☐	☐	☐	Menstrual Cramps	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Muscular Dystrophy
☐	☐	☐	Neck Pain	☐	☐	☐	Nervousness	☐	☐	☐	Numbness
☐	☐	☐	Polio	☐	☐	☐	Poor Circulation	☐	☐	☐	Hepatitis
☐	☐	☐	Rheumatic Fever	☐	☐	☐	Rheumatism	☐	☐	☐	Scarlet Fever
☐	☐	☐	Serious Injury	☐	☐	☐	Sinus Trouble	☐	☐	☐	Tuberculosis

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition _____ Date of Last Physical Exam _____

Describe Treatment _____

SURGICAL HISTORY NONE

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

ACCIDENT HISTORY NONE

☐ Job ☐ Auto ☐ Other 1. _____ Date _____

☐ Job ☐ Auto ☐ Other 1. _____ Date _____

☐ Job ☐ Auto ☐ Other 1. _____ Date _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

☐ CHECK HERE IF YOU HAVE NO SYMPTOMS AND ARE HERE FOR WELLNESS CARE

Area/Body Part	Intensity					Frequency			
	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
1. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you are experiencing pain, is it: ☐Dull ☐Sharp ☐Stabbing ☐Achy ☐Tingling/Numb ☐ _____

Since the problem started, is it: ☐About the Same ☐Getting Better ☐Getting Worse

Symptoms are worse in: ☐Morning ☐Afternoon ☐Night

Aggravated by: ☐Sitting ☐Standing ☐Laying ☐Bending ☐Coughing ☐Lifting ☐Walking ☐Turning Your Head

Other (please describe) _____

Please list any activities you avoid or cannot do due to this condition: _____

What makes your symptoms better? ☐Rest ☐Ice ☐Heat ☐Medication _____ ☐Nothing

WHEN AND HOW DID YOUR SYMPTOMS BEGIN _____

_____

☐Gradual Onset ☐Job Accident ☐Car Accident ☐Illness ☐Unknown ☐Other _____

Have you had this problem before? ☐Yes ☐No When? _____ How was it treated? _____

Name of doctor previously seen for this condition: _____

Have you ever been to a chiropractor before? ☐Yes ☐No Was it for this problem? ☐Yes ☐No

Please list all medications you are currently taking: _____

_____

Are you pregnant? ☐Yes ☐No

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING

☐Fainting	☐Fatigue	☐Loss Of Balance	☐Numb Fingers	☐Acid Reflux	☐Numbness Of Toes
☐PMS	☐Insomnia	☐Upset Stomach	☐Tingling Legs	☐Ear Infections	☐Tingling Arms
☐Constipation	☐Stiff Neck	☐Shortness Of Breath	☐Baby With Colic	☐Ringing In Ears	☐Muscle Jerking
☐Decreased Athletic Performance					