MARONE FAMILY WELLNESS CHIROPRACTIC & HOLISTIC

Today's Date: _____ *Whom may we thank for referring you?* _____

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone:_____ Cell Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Other Work Phone:_____ Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Birth Date _____ Spouse's Employer _____

Number of children and Ages: _____ Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT: When did the problem(s) begin? _____What initiated it? _____

Below LIST complaints in Order of Importance, then RATE on a scale of 1 to 10 with 10 being the worst and 0 being no pain

Primarily: _____ Rate Your Challenge 0 -- 1 -- 2 -- 3 -- 4 – 5 – 6 – 7 – 8 – 9 – 10

Second: _____ Rate Your Challenge 0 -- 1 -- 2 -- 3 -- 4 – 5 – 6 – 7 – 8 – 9 – 10

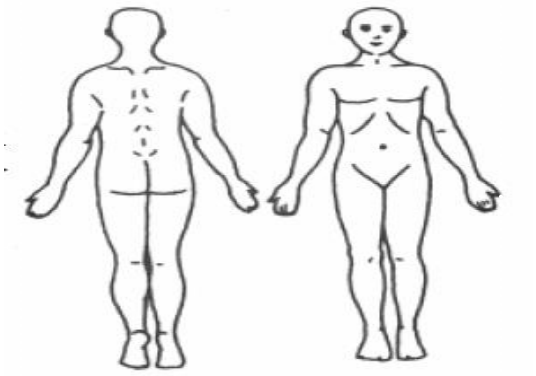
Third: _____ Rate Your Challenge 0 -- 1 -- 2 -- 3 -- 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth: _____ Rate Your Challenge 0 -- 1 -- 2 -- 3 -- 4 – 5 – 6 – 7 – 8 – 9 – 10

What relieves your symptoms? _____

What makes them feel worse? _____

Please mark on the diagram a description of your areas complaints



PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes

If yes how many times? _____ When was the last episode? _____

How did your injury happen? _____

Other forms of treatment tried: _____

Please identify jobs you have had in the past that have contributed to your problems

_____

_____

Please list any Activities whether **Social, Work, Hobbies, or Recreation** where you can have **restriction due to current complaints**.

_____

_____

FAMILY HISTORY

Does anyone in your family suffer with a similar type of condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ son(s) ☐ daughter(s)

Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

ACTIVITIES OF LIFE (indicator of functional strength)

Please Mark with the LETTER how your current conditions **MAY** be affecting your ability to carry out any of the activities below

Leave Empty if Does Not Apply **P = Painful (Can Do)** **L = Pain Limits (but Can Do)** **U = Unable to Do from pain**

___Sitting to Standing	___Bending Sideways	___Bending Forward	___Bending Backward	___Sitting on the Toilet
___Reaching	___Squatting	___Pushing	___Pulling Anything	___Interrupts Reading
___Shaving	___Bathing	___Washing/Bathing	___Interrupts Concentration	
___Sitting too Long	___Computer Sitting	___Climbing Stairs	___Lifting Children	
___Pet Care	___Yard Work	___Dressing	___Sexual Activities	
___Grocery Shopping	___Sweeping/Vacuuming	___Garbage	___Household Chores	
___Dishes	___Anything at a Sink	___Carrying Groceries	___Laundry	

Additional Activities of Concern: _____

_____

If you have ever been diagnosed with any of the following conditions, then please MARK below.

___ Broken Bone	___Dislocations	___ Tumors	___Rheumatoid Arthritis	___ Fracture	___Disability
___ Heart Attack	___Osteoarthritis	___ Diabetes	___Cerebral Vascular	___ Other serious conditions:	___Cancer

List any Prescription or Nonprescription Drug you take: _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY **OFFICE USE ONLY**

KEY:

E- Emergency Room C- Chiropractic care MD- Medical care PT- Physical Therapy C- Car accident F fall SS Spain/Strain D-dull A-ache B- burn

N- numb S- sharp R- Radiating T- throb R- radiate Am- morning Pm- evening St-Stiff RS- right side Ls Left side F-Front B- Back

PN- Pins/needles Ps- Paraspinal M- muscle L- low back N-neck MB- mid back RH-right handed LH- Left handed [--] Constant O/O- Off & On