Family Chiropractic & Massage Therapy
advance

Dr. Samantha R. Colautti, Hons. BSc., D.C.
Family Chiropractor

Please tell us about yourself

Name: _____

Name you prefer to be called: _____ Date of Birth: Day _____ Month_____ Year_____

Address: _____

_____ Postal Code: _____

Phone: Home: _____ Mobile: _____Work: _____

E-mail: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Other Children: No Yes, #_____ Age(s)_____

Family Doctor's Name: _____ Family Doctor's Phone #: _____

Emergency Contact Name: _____ Emergency Contact #: _____

How did you hear about us? _____

Health History

1. What brings you here today? Wellness or Complaint

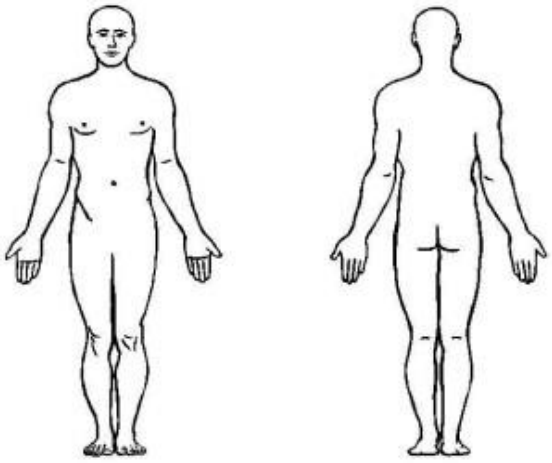
2. If a complaint, please list in order of severity:

i) _____

ii) _____

iii) _____

3. Please SHADE in the affected area(s) and CIRCLE symptoms that apply:
   Achy Stiffness Weakness Numbness Sharp
   Cramping Burning Pins & Needles



4. Have you ever had Chiropractic care before? No Yes, when: _____

Name of Chiropractor: _____ Phone #: _____

List other professionals/doctors you have consulted for these conditions:

i) _____ When: _____

ii) _____ When: _____

Did their treatment help? Explain:

_____

_____

Were X-rays, MRI or CT scans performed? No Yes When: _____

5. How does this complaint affect your life? What are you unable to do? _____

_____

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Patient Name: _____ Date: _____

6. Are you currently taking, or have you been prescribed, any Medications/Supplements or Vitamins? No Yes, please list:

_____
_____
_____

7. Please list any OPERATIONS, ACCIDENTS, and/or HOSPITALIZATIONS and when they occurred:

_____
_____
_____

8. Is there a family history of:

Cancer Arthritis Heart Disease Diabetes

Stroke Osteoporosis

9. Do you smoke? No Yes, how much per day?

Lifestyle

10. What are your hobbies/leisure time pursuits? _____

11. How many hours do you work per week on average? _____

12. What activities does your job typically involve? _____

13. In what position do you sleep most commonly? _____

14. How many hours of sleep do you get on an average night? Is it restful? _____

15. How much do you drink per day? Tea: Coffee: Pop: Alcohol: Water:

16. How would you rate your overall level of HEALTH? Mark a vertical line below:

VERY SICK ----------VERY HEALTHY

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Patient Name: _____ Date: _____

17. Please circle all the conditions you are currently experiencing and put an X beside the conditions that you have experienced in the past:

General symptoms
Headaches
Dizziness
Clumsiness
Fainting
Blackouts
Loss of consciousness
Convulsions
Sweats
Fever
Nervousness
Loss of weight
Numbness or tingling pain

Muscles and Joints
Stiff neck
Backache
Swollen joints
Painful tailbone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength

Eye, Ear, Nose & Throat
Blurred vision
Failing vision (one/both eyes)
Crossed eyes
Double vision
Eye pain
Deafness
Earache
Ringing or buzzing in ear
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Difficulty swallowing
Speech impediment

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing
Asthma

Cardiovascular
Bleeding disorder
High blood pressure
Pain over the heart
Stroke
Hardening of the arteries
Varicose veins
Swelling of the ankles
Poor circulation
Heart or blood disease
Angina

Genitourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. for Women
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

Have you ever taken birth control pills?
O yes O no

Are you now taking birth control pills?
O yes O no

# of pregnancies
children
miscarriages
therapeutic abortions

Skin
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

Gastrointestinal
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids (piles)
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer
Diabetes

Have you ever had any fractures (broken bones)? O yes O no

Other traumas

So that we may provide you with the best care, please inform the doctor if you have ever tested HIV positive or have been diagnosed with cancer. This information will be held in the strictest confidence.