Di Carlo Chiropractic

Phone Number: 636-949-5700

Patient Information

Date: ______ SSN: ______ Birthday: ______

First Name: ______ Middle Name: ______ Last Name: ______

Sex: ◯M ◯F Height: ______ Weight: ______

Marital Status: ◯Yes ◯No Spouse Name: ______ # of Children: ______

Home #: ______ Cell #: ______ Work #: ______

Address: ______

City: ______ State: ______ Zip: ______

Emergency Contact: ______ Emergency Relation: ______ Emergency Phone: ______

Email: ______

Referral Information

Referring Physician: ______ Referred Patient: ______ Referred by: ______

Advertisement: ◯Yes ◯No Advertisement: ______

Referred Directory: ◯Yes ◯No Referred Directory: ______

History

Last Physical Exam: ______ Primary Phys: ______ Phys Phone #: ______

Phys City: ______ Phys State: ______ Phys Zip: ______

Health Conditions: ______

Previous Chiro Care: ◯Yes ◯No Date: ______ Explain: ______

Chance Pregnant: ◯Yes ◯No Planning: ◯Yes ◯No

Medications: ______

Supplements: ______

Broken Bones: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: ______

Sprains/Strains: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: ______

Hospitalized: ◯Yes ◯No Explain: ______

Surgery: ◯Yes ◯No Explain: ______

Auto Accident: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: ______

Struck Unconscious: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: ______

Eating Disorder: ◯Yes ◯No Explain: ______

Stroke: ◯Yes ◯No Explain: ______

Family Health Hist: ______

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Employer Information

Employed: ◯ Full Time ◯ Part Time ◯ Homemaker ◯ Unemployed Employer Name: ______________________

Employer Address: ____

Employer City: ______________ Employer State: ______________ Employer Zip: ______________

Occupation: ______________ Work Supervisor: ______________ Supervisor #: ______________

Work Duties: ____

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease

☐ Other: ____

Patient Signature: ______________________ Date: ______________