MEROLLA CHIROPRACTIC

664 Taunton Ave. Seekonk, MA 02771
508-336-4114

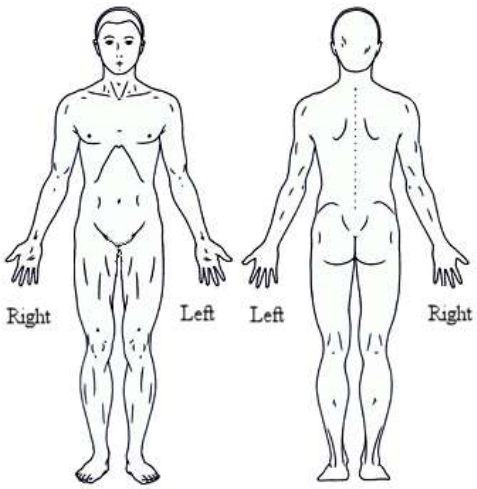
WELCOME TO OUR OFFICE

Date _____

First_____Last_____ DOB_____ Age _____
Address_____City/Town_____ State_____ Zip_____
H. Phone _____W. Phone_____ Mobile Phone _____
E-mail _____ Preferred communication? Please circle H. Phone W. Phone M. Phone E-mail
Referred by_____ Referred to particular Dr? _____
Marital Status please circle S M D W Spouse's name _____
Emergency Contact _____ Phone _____ Relationship _____
Are you currently working O Y O N Date stopped _____
PCP Name _____ Address _____ Phone _____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:
Major_____
Is this problem related to an accident? O Y O N If Yes, date of accident _____ O Auto O WC O Other _____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Stiff O Burning O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worse
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Are you under medical care for any condition?_____
What Medications are you taking?_____
Any known allergies? _____

For the Doctor's use:
Ht: _____ *Wt:* _____ *BP:* _____ *Pulse:* _____

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Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	High BP	Other_____
Father's side	O	O	O	O	O	O
Mother's side	O	O	O	O	O	O

Lifestyle: Are you a smoker? O Y O N If yes, how often? _____ Do you drink alcohol? O Y O N If yes, how often?_____
Do you exercise? O Y O N If yes, how often? _____ Light Moderate Strenuous How much water do you drink? _____ cups/oz
Stress level 1-10 (10 is highest) _____ How many hours do you sleep/night? _____ Sleep posture (circle) side stomach back

Past Health History: Have you had any surgeries? O Y O N Have you ever been hospitalized? O Y O N Have you had any traumas? O Y O N
If yes, please list any details_____
_____
_____

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Recent weight loss or gain	O Asthma or wheezing	O Loss of smell or taste
O Headaches or migraines	O Sleep apnea	O Arthritis
O Eye or vision problems	O Nausea or vomiting	O Joint pain or swelling
O Ear or hearing problems	O Diarrhea/ Constipation	O Osteoporosis
O TMJ problems	O Abdominal pain	O Cramping
O Skin trouble or rashes	O Difficulty swallowing	O Gout
O Chest pain or tightness	O Change in bowel habits	O Anemia
O Shortness of breath	O Gastic reflux	O Insomnia
O Palpitations	O Dizziness/ Fainting	O Difficulty concentrating
O Swelling of feet or hands	O Memory loss	O Agitation/Irritability
O High blood pressure	O Poor balance	O Heat/Cold intolerant
O High cholesterol or triglycerides	O Numbness or tingling	O Frequent urination
O Heart murmur	O Pins and needles	O Excessive thirst
O Blood clots	O Stroke	O Change in appetite
O Pacemaker	O Tremors	O Hyper/Hypothyroidism
O Leg pain upon walking	O Anxiety and/or panic	O painful or frequent urination
O Easily bruised	O Depression	O Blood in urine
O Persistent cough	O Sleeping issues	

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature_____Date_____