DONAHUE CHIROPRACTIC

Information Update

Name_____ Date _____

Address _____ City _____State_____Zip_____

Home Phone _____ Cell Phone _____

Email Address _____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relation_____ Phone_____

Current Conditon Information

When did your condition begin?_____

Is you condition due to an Automobile Accident? ☐Yes ☐No

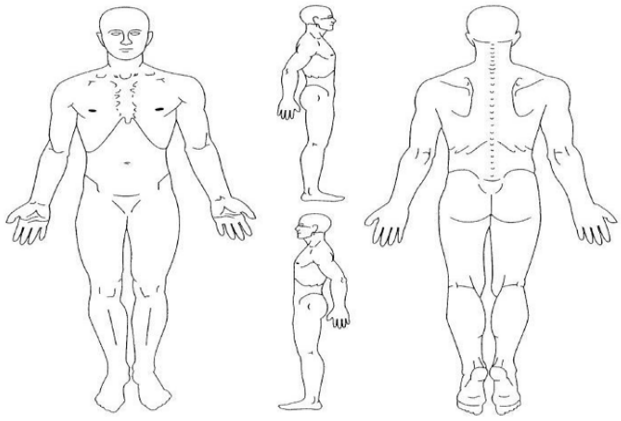
Is your condition due to an Employment Related Injury? ☐Yes ☐No If so, have you reported it? ☐ Yes ☐No

Other Doctors seen for this condition?_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning

S=Sharp T=Tingling A=Dull Ache



Have you had the same or similar symptoms before? ☐Yes ☐No

Date of prior condition_____

List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Average Pain Intensity for the last 24 hours:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Family Physican_____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications _____

_____

Allergies (Medicine, Food, Environment)_____

_____

Previous Surgeries _____

Do you have a PERSONAL history of:

☐ Cancer ☐ Diabetes ☐ Heart ☐ Disease ☐ Stroke

Other serious illnesses_____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Night Pain	☐ Pain unrelieved by rest		

Other_____

For women: Are you pregnant? ☐Yes ☐No Are you taking birth control? ☐ Yes ☐ No