

C.A.F.E. OF LIFE CHIROPRACTIC, INC. * Dr. Alfonso Di Carlo

Patient Registration & Case History

Patient Contact

Preferred to be called _____ Date _____
 Last name _____ First name _____ m.i. _____
 Address _____ City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____ E-mail _____

Patient Personal

Date of Birth _____ Age _____ Social Security # _____
 Sex male female Status single married widowed separated partnered divorced

Spouse or Guardian

Last name _____ First name _____ m.i. _____
 Employer name _____ Work phone _____

Emergency Contact (skip if emergency contact above is spouse)

Name _____ Home Phone _____
 Relationship _____ Work phone _____

Patient Employment

Employer name _____ Occupation _____
 Address _____ City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____ E-mail _____

Who referred you to our office or find out about us? _____

Health Complaints

What is your **primary** Complaint? _____

How long have you been experiencing this **primary** complaint? _____

Pain or Problem started on _____

How does the primary complaint feel? Sharp Numb Dull/achy Burning Cold

How often do you experience the primary complaint? Constant or Intermittent

And is condition Daily Weekly Monthly Yearly

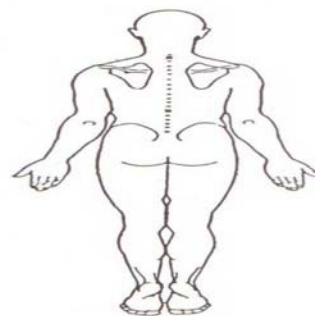
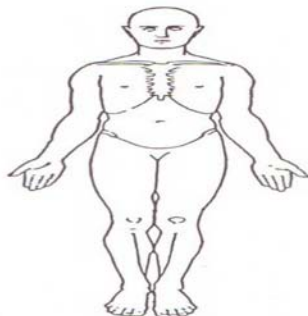
List other health complaints (2-3) below:

2 _____ 3 _____

Using the scale below, rate how your primary complaint affects your life. (**circle** only one below)

1	2	3	4	5	6	7	8	9	10
Mild, noticeable pain.	Minor pain. Annoying.	Pain is noticeable & distracting.	Moderate pain that is distracting my daily activities	Moderate pain that prevents performing some of my daily activities	Moderately strong pain interferes w/ normal activities. Difficulty concentrating	Severe pain. Social activities affected. Interferes w/ sleep.	Intense pain limits physical activity. Conversing requires great effort	Excruciating pain. Inability to have Conversation Crying out/ moaning constantly	Unspeakable pain. Bedridden and possibly delirious.

Please mark the areas of all your complaints on the diagrams on the right. include any descriptors or comments, concerning your health complaints that were not mentioned above.



Patient Case History Continued – Page 2

What activities aggravate your primary condition/pain? _____

What activities lessen your primary condition/pain? _____

Is primary condition worse during certain times of the day? morning afternoon evening bedtime

Is this primary condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this primary condition getting progressively worse? _____

Other Doctors seen for this primary condition _____

Any home remedies? _____

**What Is The Most Important Aspect In Your Life That This Complaint Has Interfered With & Why? Be Specific!
(Examples: Golf, Picking Up Kids, Work Performance, Losing Weight, Anxiety, Etc...)**

List Here →

System review:

General

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> consistent fainting | <input type="checkbox"/> dizziness | <input type="checkbox"/> tension | <input type="checkbox"/> depression |
| <input type="checkbox"/> loss of sleep | <input type="checkbox"/> fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> headache |
| <input type="checkbox"/> loss or weight gain | <input type="checkbox"/> nervousness | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> pins & needles in arm/legs | <input type="checkbox"/> numbness in toes/fingers | <input type="checkbox"/> loss of smell/taste | <input type="checkbox"/> loss of balance |

Gastro-Intestinal

- | | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> gall bladder/liver problems | <input type="checkbox"/> nausea | <input type="checkbox"/> poor appetite | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | <input type="checkbox"/> poor digestion | <input type="checkbox"/> vomiting blood |

Eyes/Ears/Nose/Throat

- | | | | |
|--------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> pain in eyes | <input type="checkbox"/> poor vision |
| <input type="checkbox"/> ear noises | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> earache | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever | <input type="checkbox"/> sinusitis |

Respiratory

- | | | | |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> spitting phlegm |
|-------------------------------------|--|---|--|

Muscles/Joints/Bones

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> backache | <input type="checkbox"/> foot problems | <input type="checkbox"/> pain bet. Shoulders | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> spinal curvature | <input type="checkbox"/> swollen joints | <input type="checkbox"/> twitching | <input type="checkbox"/> weakness |

Cardio-Vascular

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> heart trouble | <input type="checkbox"/> pain over heart |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> slow/rapid heart | <input type="checkbox"/> strokes | <input type="checkbox"/> high blood pressure |

Skin or Allergies

- | | | | |
|---|----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> dryness | <input type="checkbox"/> eczema | <input type="checkbox"/> hives |
| <input type="checkbox"/> sensitive skin | <input type="checkbox"/> itching | | |

Women

- | | | | |
|---------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> cramps | <input type="checkbox"/> hot flashes | <input type="checkbox"/> irregular cycle | <input type="checkbox"/> painful periods |
|---------------------------------|--------------------------------------|--|--|

Medications	Reason	How Long?	Any Side Effects?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

List any broken bones or dislocations & date: _____ Year _____ Year _____
 _____ Year _____ Year _____ Year _____

Is there a family history of: Check if no history

	Heart Disease	Arthritis	Cancer	Diabetes	Kidneys	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree to the following: A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services. It is my responsibility to complete the clinic's forms accurately. It is my responsibility to notify the doctor if any of my information has changed or requires updating. My case may not be accepted for treatment at this office and I will be advised of applicable cost for any additional services if doctor believes that I may respond to their care.

Signature

Date