GRACIANO FAMILY CHIROPRACTIC

600 W PECAN TREE RD
Waxahachie Tx 75167
4696886731
Gracianofamilychiro@gmail.com

1. Contact information

Full Name

Mobile Phone

Home Phone

Primary Email

Emergency contact-Name and Number

Date of Birth

Social Security

Home Address

2. Demographic Information

Sex at Birth

☐ Male ☐ Female

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

3. Current complaint

☐ Neck ☐ Mid Back ☐ Low Back

☐ Upper Extremity ☐ Lower Extremity

4. How long have you had this condition?

○ 1-3 Days ○ 1-2 Weeks ○ 1-2 months

○ Years

5. Intensity of Pain 1-10

○ 1 mild ○ 2 ○ 3

○ 4 ○ 5 moderate ○ 6

○ 7 ○ 8 ○ 9

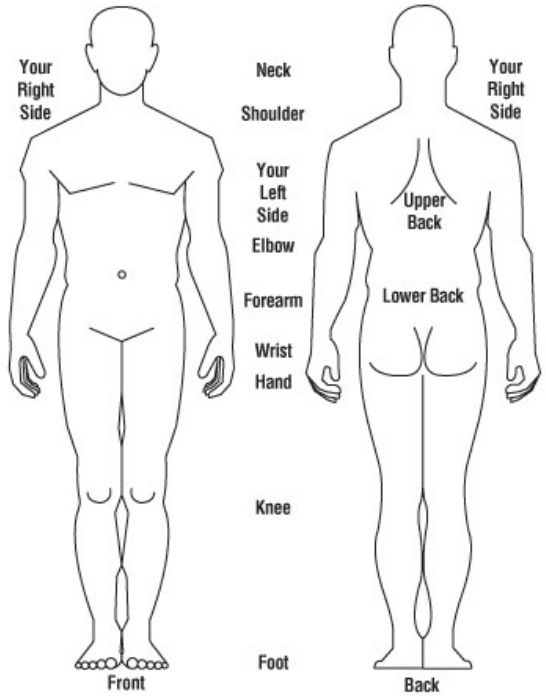
○ 10 Extremely Severe

6. Have you seen a physician or other health practitioner about this? If 'yes', when? What was the diagnosis (if any)?

7. What aggravates this condition?

- ☐ Bending
- ☐ Lifting
- ☐ Walking
- ☐ Coughing/Sneeze
- ☐ Any movement
- ☐ Going up Stairs

8. Please indicate areas of concern:



9. Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? If 'yes', please list approximate dates.

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10. Cardiovascular Please check the boxes for any condition(s) you have experienced or are experiencing:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Stroke/CVA
- ☐ Phlebitis/varicose veins
- ☐ Heart disease
- ☐ Pacemaker or similar device(s)

11. Respiratory Please check the boxes for any condition(s) you have experienced or are experiencing:

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

12. Bone Health

History of Fractures?
○ Yes ○ No

If 'yes", please describe.

_____

13. Diabetes

○ Yes ○ No

If 'yes", please specify onset and type.

_____

14. Head / Neck Please check the boxes for any condition(s) you have experienced or are experiencing:

- ☐ History of headaches
- ☐ History of migraines/ new onset?
- ☐ Vision loss/changes
- ☐ Dizziness/Double vision
- ☐ Hearing loss/ear condition(s)

15. Please list any previous surgical procedures and any details/hardware (i.e. prosthesis, wires, internal pins/fixators).

_____

_____

_____

_____

16. Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics) and specify the date your started using it and dosage.

	Medication	Date first use	Dosage
1			
2			
3			

17. Anything else we should know about your health or Physicotherapy expectation?

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