Welcome to Dolan Family Chiropractic!

Your family will receive the care and attention they need from our family!

About You…

Name: _____ Date: _____
Address: _____ City_____ State_____ Zip_____
Birthday:_____ Phone Number:_____
Marital Status: ____S _____M ____D ____W Spouse's name: _____
# of Children: _____ Names:_____
Emergency Contact Name:_____ Relation:_____ Phone#_____
Occupation: _____
How did you hear about our office? _____

Reason For Visit…

What is your chief complaint?
_____
_____
When did the problem start and how do you believe your problem began?
_____
_____
Have you ever had this condition or something similar before? When? _____
_____
What makes it better? _____
What makes it worse? _____
Have you been under the care of another health care provider for this condition? When?
_____
Have you ever been in any accidents? (ie. Auto, falls, accidents)_____
_____
Have you ever been seen by a chiropractor? _____
What surgeries have you had? _____ Year _____
_____ Year _____
_____ Year _____
Are you pregnant? ___If yes, provide due date/Dr's name?_____
_____

Current: Height: _____ Weight:_____ Blood Pressure issues? ___Yes ___No
Have you lost or gained weight in the past year? How much? _____
How do you characterize your stress levels? _____High _____Medium _____Low
Habits: Cigarettes _____ *Quantity*: _____ Alcohol _____ *Quantity*: _____
Coffee _____ *Quantity*: _____ Water _____ *Quantity*: _____
Do you exercise? How often? What activities? _____
_____
What medication are you taking? (Including aspirin, etc) _____
_____
What vitamins and supplements do you take? _____
_____

Medical History… ***ROS Reviewed_____***

Have you **recently had** or **do you now have** any of the following symptoms which are or have been significant distress to you?

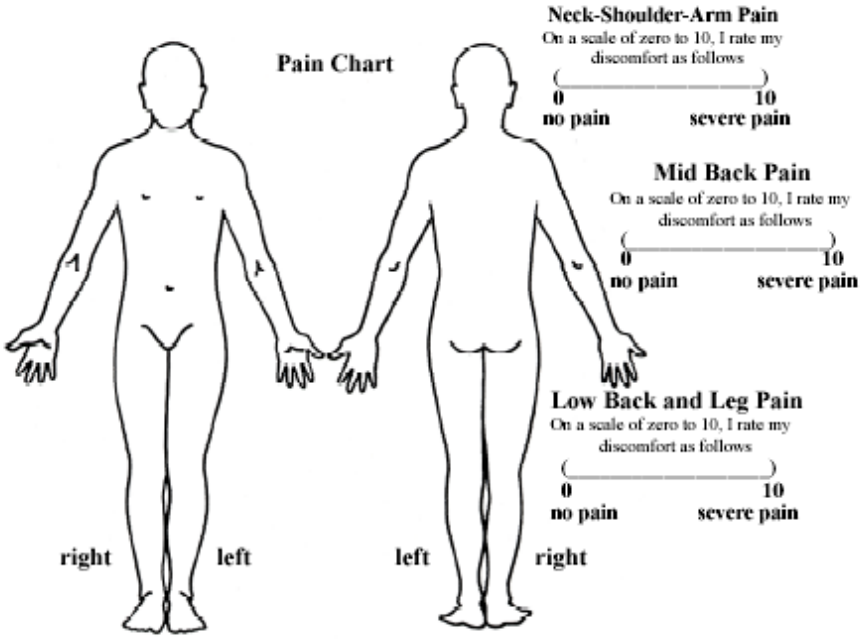
	Now	Past		Now	Past
Headaches	____	____	Loss of Balance	____	____
Neck Pain	____	____	Sleeping Problems	____	____
Stiff Neck	____	____	Seizures	____	____
Fainting	____	____	Stroke	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Kidney Problems	____	____
Upset Stomach	____	____	Shoulder/Arm/Hip/Knee Pain	____	____
Constipation	____	____	Pins & Needles in Arm	____	____
Cold Sweats	____	____	Pins & Needles in Legs	____	____
Fever	____	____	Numbness in Fingers	____	____
Sinus Problems	____	____	Numbness in Toes	____	____
Diabetes	____	____	High/Low Blood Pressure	____	____
Heart Attack	____	____	Difficulty Urinating	____	____
Allergies	____	____	Leg Cramps	____	____
Cancer	____	____	Weakness in Arms	____	____
Gall Bladder	____	____	Weakness in legs	____	____
Indigestion	____	____	Shortness of Breath	____	____
Fatigue	____	____	Menstrual Difficulties	____	____
Depression	____	____	Nausea/Vomiting	____	____
Asthma	____	____	Lights Bother Eyes	____	____
Swelling Joints	____	____	Loss of Memory	____	____
Ears Ring	____	____	Artificial joints/pacemaker	____	____

Family History…

Do you have a family history of: (Please mark M for mother, F for father, S for sibling)

____High Blood Pressure ____Thyroid Disease ____Stroke _____ Cancer
____ Heart Disease ____Headaches ____Osteoporosis _____ Back Pain
____Depression or Anxiety ____ Stroke ____ Arthritis _____Diabetes

Please mark the areas of pain or sensation on the body diagram below.



Feel free to use these listed symbols to describe the type of pain you are experiencing.

Numbness ----------

Aching **********

Burning xxxxxxxxxxxxxx

Pins & Needles oooooooo

Stabbing ++++++++++++