RUGGIERO FAMILY CHIROPRACTIC
& REHABILITATION CENTER, LLC

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CONFIDENTAL PATIENT INFORMATION

This information is confidential. In order for us to understand your health problems properly, please complete this form.

Date: _____ Chart #: _____

Name: _____ Cell Phone#: _____

Address: _____ City/Zip:_____

Date of Birth: _____ Marital Status: S M W D # Children:_____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

How Did You Hear About This Office? _____

Diagnosing/Referring Practitioner: _____

Please List the Main Health Problems You Would Like to Be Free of in Order of Importance:

1._____

2._____

3._____

How And When Did These Conditions Begin? _____

How Do They Impair Your Daily Activities? _____

Health Professionals Seen for Them:_____

_____

_____

PAST MEDICAL HISTORY:

WHAT SURGERIES HAVE YOU HAD?
(Type/When/Doctor/Results)_____
_____
_____

LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)
(What/When/Symptoms/Treatment)_____
_____
_____

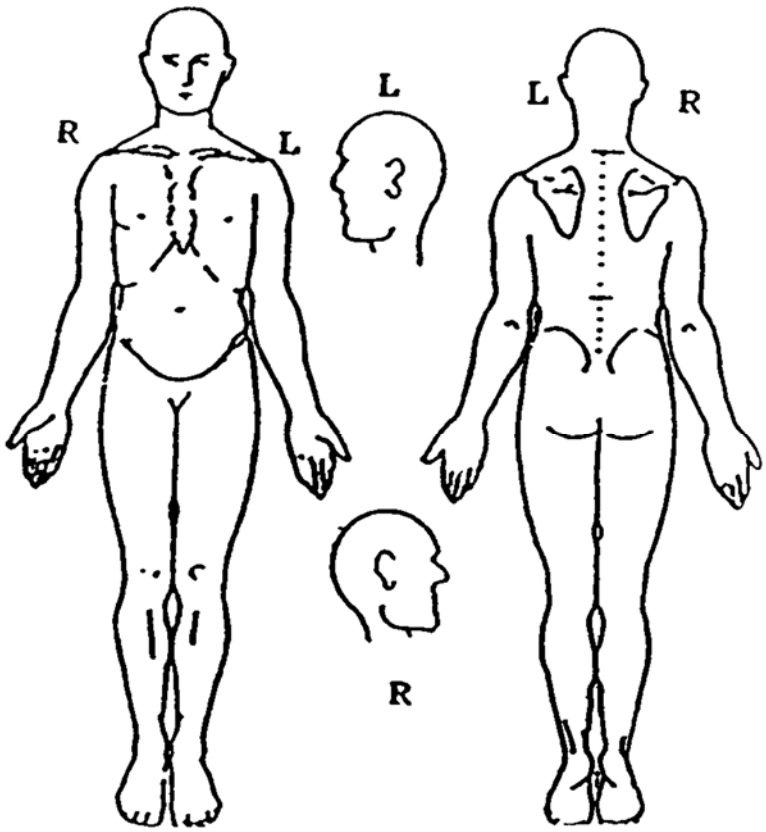
BROKEN BONES, DISLOCATIONS?
(When/How/Doctor/Results)_____
_____
_____

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE
(What/Frequency/Doctors/Side Effects/Remarks)_____
_____
_____

LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED
(Ex: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression)
_____
_____

WORK ACTIVITIES
Work Responsibilities – Lifting, bending, stooping, turning, twisting, carrying, walking, standing, sitting etc.
_____
_____

LEISURE ACTIVITIES
Sports and exercise type, frequency, length of time, etc. _____
_____
_____



PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT, ON THE DIAGRAM ABOVE

Pain is: (check all that apply): Sharp [ ] Burning [ ] Moving [ ] Fixed [ ] Dull [ ] Aching [ ] Stabbing [ ] radiates to:_____

Please check if you ever have had any of the following			
☐	AIDS	☐	Hives
☐	Positive test for AIDS/HIV antibodies	☐	Kidney stones
☐	Blood transfusions	☐	Kidney or bladder infection
☐	Bone disease	☐	Liver disease
☐	Bronchitis	☐	Low blood pressure
☐	Bursitis	☐	Lupus
☐	Cancer or tumor	☐	Malaria
☐	Chicken pox	☐	Measles
☐	Colon/bowel disease	☐	Mononucleosis
☐	Allergies	☐	Mumps
☐	Anemia	☐	Pancreatitis
☐	Arthritis	☐	Pleurisy
☐	Asthma	☐	Pneumonia
☐	Diabetes	☐	Polio
☐	Diphtheria	☐	Prostatitis
☐	Drug habit	☐	Rheumatic fever
☐	Drug sensitivity or reaction	☐	Scarlet fever
☐	Emotional or mental problems	☐	Small pox
☐	Emphysema	☐	Spinal meningitis
☐	Gall stones	☐	Stomach or duodenal ulcer

☐	Gall bladder problems		☐	Tendonitis
☐	German measles		☐	Tuberculosis
☐	Heart trouble		☐	Thyroid or goiter trouble
☐	Heart murmur		☐	Typhoid
☐	Hemorrhoids		☐	Venereal disease
☐	Hepatitis/jaundice		☐	Varicose veins
☐	Herpes		☐	Whooping cough
☐	High blood pressure		☐	

If you have had any of the following symptoms, check the box that tells us if the symptom was in the past or if it is current. Also, circle one of the numbers that appears to the right of the symptom.

(Circle 1 for the least severe, and 5 for the most severe.)

Past	Current	Symptom	1=least severe 5=most severe		Past	Current	Symptom	1=least severe 5=most severe
☐	☐	Abdominal/stomach pain	1 2 3 4 5		☐	☐	Frequent or extended hoarseness	1 2 3 4 5
☐	☐	Always hungry	1 2 3 4 5		☐	☐	Hearing difficulties	1 2 3 4 5
☐	☐	Black stools	1 2 3 4 5		☐	☐	Nose bleeds	1 2 3 4 5
☐	☐	Constipation	1 2 3 4 5		☐	☐	Sinus problems	1 2 3 4 5
☐	☐	Diarrhea	1 2 3 4 5		☐	☐	Sore throats	1 2 3 4 5
☐	☐	Heartburn	1 2 3 4 5		☐	☐	Sounds/ringing in ears	1 2 3 4 5
☐	☐	Indigestion	1 2 3 4 5		☐	☐	Swollen glands	1 2 3 4 5
☐	☐	Gas	1 2 3 4 5		☐	☐	Trouble with your eyes	1 2 3 4 5
☐	☐	Lack of appetite	1 2 3 4 5		☐	☐	Unusual taste in mouth	1 2 3 4 5
☐	☐	Nausea	1 2 3 4 5		☐	☐	Dry skin	1 2 3 4 5
☐	☐	Overweight	1 2 3 4 5		☐	☐	Itching or burning skin	1 2 3 4 5
☐	☐	Unusually thirsty	1 2 3 4 5		☐	☐	Skin rash	1 2 3 4 5
☐	☐	Vomiting	1 2 3 4 5		☐	☐	Bloody urination	1 2 3 4 5
☐	☐	Weight changes	1 2 3 4 5		☐	☐	Burning urination	1 2 3 4 5
☐	☐	Bleeding easily	1 2 3 4 5		☐	☐	Difficult urination	1 2 3 4 5
☐	☐	Bleeding gums	1 2 3 4 5		☐	☐	Frequent urination	1 2 3 4 5
☐	☐	Bruising easily	1 2 3 4 5		☐	☐	Loss of bladder control	1 2 3 4 5
☐	☐	Chest pain or pressure	1 2 3 4 5		☐	☐	Painful urination	1 2 3 4 5
☐	☐	Dizzy spells or blackouts	1 2 3 4 5		☐	☐	Urination at night	1 2 3 4 5
☐	☐	Irregular heart beat	1 2 3 4 5		☐	☐	Concerns about sexual function	1 2 3 4 5
☐	☐	Poor circulation	1 2 3 4 5		☐	☐	Convulsions	1 2 3 4 5
☐	☐	Pounding heart beat	1 2 3 4 5		☐	☐	Depression	1 2 3 4 5
☐	☐	Racing heart beat	1 2 3 4 5		☐	☐	Fatigue or tiredness	1 2 3 4 5
☐	☐	Chest colds	1 2 3 4 5		☐	☐	Frequent or severe headache	1 2 3 4 5
☐	☐	Chronic cough	1 2 3 4 5		☐	☐	Difficulty getting to sleep	1 2 3 4 5
☐	☐	Congested nose	1 2 3 4 5		☐	☐	Difficulty staying asleep	1 2 3 4 5
☐	☐	Coughing up blood	1 2 3 4 5		☐	☐	Leg cramps	1 2 3 4 5
☐	☐	Smoking	1 2 3 4 5		☐	☐	Nervousness	1 2 3 4 5
☐	☐	Sneezing	1 2 3 4 5		☐	☐	Numbness or tingling	1 2 3 4 5
☐	☐	Wheezing	1 2 3 4 5		☐	☐	Shaking or trembling	1 2 3 4 5
☐	☐	Chills	1 2 3 4 5		☐	☐	Stuttering or stammering	1 2 3 4 5
☐	☐	Excessive sweating	1 2 3 4 5		☐	☐	Back trouble	1 2 3 4 5
☐	☐	Fever	1 2 3 4 5		☐	☐	Pain or swelling-any joint	1 2 3 4 5
☐	☐	Lack of perspiration	1 2 3 4 5		☐	☐	Painful feet	1 2 3 4 5
☐	☐	Night sweats	1 2 3 4 5		☐	☐	Painful muscles	1 2 3 4 5
☐	☐	Tendency to be too cold	1 2 3 4 5		☐	☐	Stiff or painful neck	1 2 3 4 5
☐	☐	Tendency to be too hot	1 2 3 4 5		☐	☐	Swelling of feet or legs	1 2 3 4 5
☐	☐	Earaches	1 2 3 4 5		☐	☐		1 2 3 4 5

Check if you have family history of any of these							
☐	AIDS		☐	Diabetes		☐	Mental illness
☐	Allergies		☐	Epilepsy		☐	Problems with alcohol
☐	Anemia		☐	Glaucoma		☐	Stroke
☐	Arthritis		☐	Gout		☐	Thyroid disease
☐	Asthma		☐	Heart disease		☐	Other potentially inheritable disease
☐	Cancer		☐	High blood pressure		☐	

The Following Section is for Women

Past	Current	Symptom	1=least severe 5=most severe		Past	Current	Symptom	1=least severe 5=most severe
☐	☐	Abdominal pain or cramping with menstruation	1 2 3 4 5		☐	☐	Irregular periods	1 2 3 4 5
☐	☐	Abnormal PAP smear	1 2 3 4 5		☐	☐	I.U.D.	1 2 3 4 5
☐	☐	Abortion	1 2 3 4 5		☐	☐	Menopause	1 2 3 4 5
☐	☐	Back pain with menstruation	1 2 3 4 5		☐	☐	Miscarriage	1 2 3 4 5
☐	☐	Birth control pills	1 2 3 4 5		☐	☐	Premenstrual tension/syndrome	1 2 3 4 5
☐	☐	Bleeding between periods	1 2 3 4 5		☐	☐		1 2 3 4 5
☐	☐	Bleeding during or after intercourse	1 2 3 4 5		☐	☐	Pregnancy	1 2 3 4 5
☐	☐	Bloating before periods	1 2 3 4 5		☐	☐	Scanty bleeding with period	1 2 3 4 5
☐	☐	Blood discharge from nipples	1 2 3 4 5		☐	☐	Tubal ligation	1 2 3 4 5
☐	☐	Breast lumps	1 2 3 4 5		☐	☐	Sickness/weakness with period	1 2 3 4 5
☐	☐	Heavy bleeding with period	1 2 3 4 5		☐	☐	Vaginal discharge	1 2 3 4 5
☐	☐	Hot flashes	1 2 3 4 5		☐	☐	Vaginal dryness or itching	1 2 3 4 5
Duration of menstrual periods:								
Interval between periods:								
Dates of last period:								
Number of births you have had								
Ages of your children:								
Birth control method you use:								