Welcome to the Office of Dr Joe's Distinctive Chiropractic
G M Nunnari, PC 240-731-0264

PERSONAL INFORMATION

Today's Date:_________________________

Name of Person Who Referred You To This Office?
☐ Medical Doctor______________________ ☐ Patient ________________________ ☐ Other___________________

Your Full Name:____ What you prefer to be called:_________________

Birth Date:______/______/_______ Age: ___________ Gender: ☐ Male ☐ Female

Address:_______________________________________ Circle One: Married Single Widowed Divorced Separated

City/State/Zip: __________________________________ Home **Phone**:_________-_________-________________

Employer:_______________________________________ Work **Phone**: _________-_________-________________

Occupation:_____________________________ _____yrs. Cell **Phone**: __________-_________-________________

Your **E-mail Address** and/or website: ____

IN CASE OF EMERGENCY

Who to Contact?_________________________________ Relation:____

Phones: Home:_______________________ Work:_______________________ Cell: ________________________

Who Is Your Medical Doctor?_______________________________________ Phone:___________________________

WHY ARE YOU SEEKING CARE?

Please describe Your Chief Complaint:____
____.

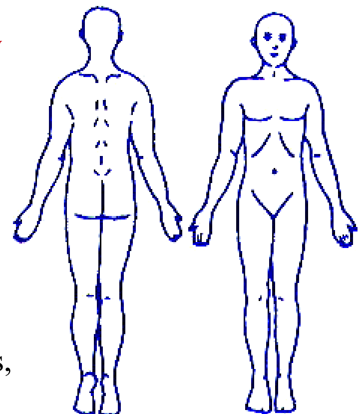
My **Pain Scale**

Rate your pain or discomfort level by circling the appropriate number of intensity→**min__1__2__3__4__5__6__7__8__9__10__max**

Use the following Figures and Symbols to describe the areas and type of your chief complaint……………

When / How did this problem begin?____________________________
Does it limit any movements or activities?_______________________
Has this problem occurred before?_______When?__________________
Other doctors, chiros, physical therapists, etc. seen for this condition:
____
____
Type(s) of treatment received:____
____
Results of treatment:_________________________________.

Sharp Pn. = S
Weakness = W
Dull Ache = A
Numbness = N



List of ALL Meds (prescription, homeopathic and over-the-counter) nutraceuticals, vitamins, minerals, herbs or other remedies you are taking:___________________
____
____
____
____
____.

CONTINUE NEXT PAGE

Page Two HEALTH HISTORY

Check and/or Describe with Dates:
Operations/Surgery: Appendix Back Surgery Broken Bones Tonsils Gall Bladder Hernia Hysterectomy
 Other____

Major Accidents or Falls____

Hospitalization (other than above)____

List your **relatives** who had or have: Arthritis____________________ Blood Clots ________________
 Coronary Artery Disease__________________ Diabetes_________________ Disc Herniation ___________

Your intake: Alcohol ______oz. per day Cola/Soft Drinks ______ oz. per day
 Cigarettes _______ per day Red Meat _____ servings per week
 Coffee ______cups per day Tea(regular, non herbal) ______ cups per day
What is your BMI? ______ Refined Sugar _____ per day

CHECK ANY OF THE FOLLOWING **DISEASES YOU HAVE EVER HAD**:

 Anemia
 Arthritis
 Chicken Pox
 Celiac
 Depression
 Measles
 Eczema
 Epilepsy
 Heart Disease/Attack
 Influenza
 Kidney Stones
 Pneumonia
 Mental Disorders
 Mumps
 Low Back Syndrome
 Polio
 Pleurisy
 Urinary Tract Infection
 Whooping cough
 Cancer Type________________
 Diabetes Type_______________

CHECK ANY OF THE FOLLOWING **DISEASES YOU HAVE HAD IN THE PAST 6 MONTHS**:

 Allergies
 Angina
 Ankle Swelling
 Arm Pain
 Anxiety Attacks
 Bladder Infection
 Blood in Stool
 Blood in Urine
 Breast Pain/Lumps
 Chest Pain
 Colitis
 Constipation
 Convulsions
 Excessive Hunger
 Excessive Thirst
 Fainting
 Frequent/Excessive
 Gall Bladder problems
 Gas/Bloating after meals
 Headaches
 Heartburn
 HIV positive
 Insomnia
 Irregular Heartbeat
 Joint Pain/Stiffness
 Kidney Trouble
 Liver Problems
 Low Back Pain
 Menstrual Pain/Swelling
 Nausea and Vomiting
 Neck Pain
 Night Pain
 Numbness
 Painful Urination
 Pain between Shoulders
 Paralysis
 Prostatitis/ BPH
 Rheumatic Fever

If FEMALE, Are You Pregnant? No Yes, How many months?___ Not sure
What was the date of your last period?__________ How many children have you delivered?___________

IMPORTANT: What are your treatment objectives? Please choose in which you are interested. Relief of pain or discomfort (Relief Care), or Correcting the cause of those symptoms (Correction Care).

I desire: Relief Care Corrective Care Not sure, I want Doctor to make recommendations for care

<u>You must READ AND SIGN to the following:</u>

I hereby authorize Dr Joe to evaluate me and my condition. I understand that ***Dr. Nunnari operates a fee-for-service healthcare business that DOES NOT participate with any insurance plans or Medicare****, and that I am fully responsible for paying all fees incurred on the date that services are rendered. I recognize that medical insurance is an arrangement between me and my insurance carrier(s). Should I desire to submit claims to them, I can do so at my own risk, by using the "Patient Statement of Account" which Dr. Nunnari will provide to me at the end of each visit.* ***If an insurance carrier requires additional documentation for them to pay me, and I request that the doctor comply with them, the doctor will charge me all incurred and appropriate fees to provide any additional letters, records, reports or other correspondence the insurance company may require or demand of him.***

Patient Signature____ Date_________________________