# Dr Joe Nunnari's Distinctive Chiropractic
# Patient Intake + Postural Assessment Form

Name _____ Date_____

Address _____ Zip Code _____

Home Phone_____ Work Phone _____ Cell Phone _____

How Referred to this office? Web Search_____ Doctor _____ Friend/Relative_____

Date of Birth _____ Height _____ Weight _____ Email address_____

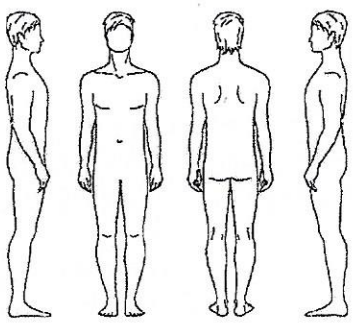
Previous Chiropractic Treatment?_____Dr:_____

For what condition?_____

**How/When** did your current problem begin? _____

_____

On the figures at right, **Circle** those areas of your pain or discomfort



**Describe** the type of discomfort (numbness, tingling, sharp, dull ache, etc)

_____

_____

_____

**Rate** your symptom intensity when it's the worst, (1-10, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Do you or have you had any of the following conditions?
__Anemia __Headaches __Diabetes __Kidney Stones
__Chest Pain __Hypertension __Epilepsy __HIV __Rheumatoid __Metal Implants __Pain at night __Cancer __Prostate
__Foot Drop __Heart Disease __Celiac __Stroke __Depression __Arthritis __Heart Attack __Phlebitis __Bunion(s)
__Sciatica __Bladder infection

What activities do you do the most?

| | Most of the Day | Half of the Day | Little of the Day |
|---|---|---|---|
| Sit | | | |
| Stand | | | |
| Computer work | | | |
| Drive | | | |
| Walk | | | |
| Run | | | |
| Manual Labor | | | |

How many days per week do you wear these kinds of shoes?

Athletic _____

Dress _____

High Heels _____

Flats _____

Industrial _____

**Please read and sign to the following:**

I hereby request and authorize Dr Nunnari to examine me and evaluate my condition. I understand that he is a fee-for-service healthcare provider and DOES NOT PARTICIPATE with Medicare, Medicaid or any other insurance networks. I am solely and fully responsible for paying fees for all services which are due on the date that I receive them. I understand that medical insurance coverage is an arrangement between me and my insurance carrier(s). Should I desire to submit claims to them, I shall do so at my own effort, risk and peril, using the "Statement of Patient Account" which Dr Nunnari shall provide me at the end of each visit. Should an insurance company require additional documentation for them to pay me and I request that the doctor provide more information, the doctor will charge me all incurred and appropriate fees for writing letters, completing forms and reports, or other correspondence.

Patient Signature _____ Date _____