

Healing Hands Chiropractic



Dr. Beth Tedesco, D.C.
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Patient Information

*Thank you for choosing our practice for your chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

Name: (First) _____ (Last) _____

Date: _____ I would like to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Social Security #: _____

Are you? Male Female Married Single Widowed Divorced Separated
 African American Asian Caucasian Hispanic Other

Do you have children? Yes No Ages: _____

Your Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's or Parent's Name: _____ Workplace: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Symptoms

Reason for visit: _____

When did your problem begin? _____

Did it begin suddenly gradually progressively over time

Did it start from an injury: Yes No what happened? _____

Is this condition getting: Better Worse staying the same

Have you experienced a similar problem before? _____

Where specifically is the problem(s) located? _____

Type of pain: Dull Sharp Aching Shooting Spasm Throbbing
 Burning Numbness Tingling

Rate the severity of your pain (1 - no pain or discomfort to 10 - severe pain):

0 1 2 3 4 5 6 7 8 9 10

Is the pain constant? _____

What makes it better? _____

What makes it worse? _____

What treatment have you already received for your condition? _____

Medication Surgery Physical Therapy Chiropractic Other _____

Name and address of other practitioner(s) who have treated you for your condition: _____

Other areas of concern: _____

Health History

Check conditions that apply

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abnormal Weight Loss | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Abnormal Weight Gain | <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Disc Disorder | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Migraine Headaches | |

Other: _____

Date of last medical exam? _____ Who did you see? _____

(Women) Are you pregnant? Yes No Nursing? Yes No

List any surgeries you have had and any times you have been hospitalized (include dates):

List any accidents or injuries and the dates they occurred (include broken bones):

Please list all medications that you are currently taking and the reasons:

Have you ever been seen by a chiropractor before? Yes No When? _____

For what condition? _____

Family History

Does anyone in your family have a condition similar to yours? Yes No Who? _____

Does anyone in your family have?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Arthritis, Type: _____ | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Disc Disorders |
| <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Headache, Type: _____ | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke | |

Daily Habits

What type of exercise do you perform? _____

What do your daily work habits include (i.e.: sitting, standing, light labor, heavy labor, computer work):

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? Yes (How many packs per day? _____) Never Smoker Former Smoker

How much alcohol do you consume per day? _____ Caffeinated Beverages? _____

Authorization

I certify that I have read and understand, and answered the above information to the best of my knowledge. I authorize Dr. Tedesco to perform a chiropractic evaluation, and if appropriate, treatments for my condition. I authorize Healing Hands Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Healing Hands Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of Patient (or parent if a minor)

Date