WELCOME

one

ABOUT YOU

Today's Date: ______________ File #: ______________

Patient Name: ______________

What You Prefer To Be Called: ______________

Birthdate: ______________ Age: ______

Mailing Address: ______________

____

Home Phone #: ______________

Work Phone #: ______________ Ext: ______

Other Phone #s: ______________

E-Mail Address: ______________

Referred By: ______________

Employer: ______________ How Long? ______

Employer's Address: ______________

____

Occupation: ______________

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: ______________

Do you have children ? ☐ Yes ☐ No How many? ______

REASON FOR YOUR VISIT

The reason for this visit is a result of (Please circle): work, sport, auto, trauma or chronic.

(*Explain what happened*): ______________

____

Please describe the pain & its location: ______________

____

When did condition begin? ______________

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with you (*Please Circle*): work, sleep or daily routine

If so, please explain: ______________

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: ______________

Have you been treated by a Medical Physician for this condition? ☐ Y ☐ N

If so, where? ______________

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? ______________ Phone#: ______________

two

Dr. Richard Sillipo B.Sc. D.C.
Studio Chiropratica Benessere +011 0907617

3 three

IN EVENT OF EMERGENCY

Who should we contact? ____________________

Relation: ____________________

Home Phone #: __________ Work Phone #: __________

Who is your Medical Doctor? __________ Phone #: __________

HEALTH HISTORY

Are you taking any of the following medications?

☐Nerve Pills ☐Pain killers (including aspirin) ☐Muscle relaxers ☐Stimulants ☐Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) __________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Singles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/ Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:
____

Please list anything that you may be allergic to : __________
____

List previous surgeries/treatments with dates: __________
____

List any **past** serious accidents with dates: __________
____

Family Health History: __________
____

Do you: Take Supplements or Vitamins? ☐Yes ☐No / Exercise ☐Yes ☐No

Are you on a special diet: ☐Yes ☐ No / Since: ____/____/____

Do you smoke? ☐ No ☐ Yes/ How Much? ______ How Long? ______

Are you wearing: ☐Heel Lifts ☐ Sole lifts ☐Inner soles ☐Arch s upports

What is the age of your mattress? _____ Is it comfortable? ☐Yes ☐ No

For women: Are you taking Birth Control? ☐Yes ☐ No

Are you Pregnant? ☐No ☐ Yes/How long? _____ Nursing? ☐Yes ☐No

- We invite you to discuss with us any questions regarding you services. The best health service are based on a friendly mutual understanding between provider and patient.
- Our policy requires payment in full or all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid with 90 days of the days of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting your account.
- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.
- I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. And guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____________________ Date ____/____/____

☐ Adult ☐ Patient or Guardien ☐ Spouse

Dr. Richard Sillipp D.Sc., D.C.
Centro Chiropratica Benessere
Tel 020 7617