NOLAN CHIROPRACTIC

Dr. Robert Nolan

Cell Number ______________
Email Address ______________

CONFIDENTIAL PATIENT INFORMATION

Date ______________ SS # ______________

Name ______________ Phone # ______________

Local Address ______________ City/State/Zip ______________

Other Address ______________ City/State/Zip ______________

Age ______ Birth Date ____ / ____ / ____ Marital Status S M W D How many children ______

Occupation ______________ Employer ______________ Work phone # ______________

Work Address ______________ City/State/Zip ______________

Name of Spouse ______________ Occupation ______________ Employer ______________

Work Address ______________ City/State/Zip ______________ Phone # ______________

Who referred you to our office? ______________

INSURANCE CO ______________

List present complaints, injuries and duration and when specifically the symptoms or pain began:

1. ______________
____

2. ______________
____

Brief remarks and details of any recent related accident:

____
____
____

Are symptoms

( ) getting worse, ( ) getting better, or ( ) staying the same?

List any doctors consulted for present complaints and injuries:

Name ______________ Specialty ______________

Address ______________

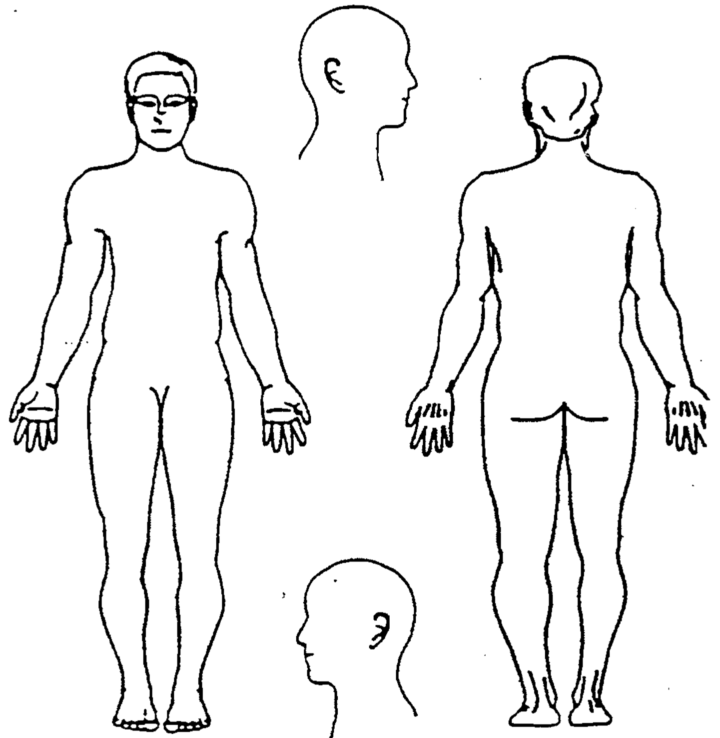
Consulted from ______________ to ______________

Name ______________ Specialty ______________

Address ______________

Consulted from ______________ to ______________

Please mark your areas of pain on the figures below



0 ______________ 5 ______________ 10

How bad is your pain (circle 0 no pain to 10 unbearable)

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Please (circle) current conditions - (✓) check former conditions
*(Please give details on any marked areas at the bottom of the page.)

GENERAL SYMPTOMS
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Gain/Loss of Weight
- ☐ Numbness/pain in arms, hands, legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Neuralgia/neuritis
- ☐ Depression

E.E.N.T.
- ☐ Failing vision
- ☐ Near sightedness
- ☐ Far sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever

E.E.N.T. continued
- ☐ Tinnitus
- ☐ Asthma
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

SKIN
- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hive or allergy

RESPIRATORY
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing

CARDIOVASCULAR
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure

CARDIOVASCULAR cont'd
- ☐ Pain over heart
- ☐ Previous heart attack
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Aneurysm

MUSCLE & JOINT
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Pain in shoulders
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Difficult digestion
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis

FOR WOMEN ONLY
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Congested breast
- ☐ Lumps in breast
- ☐ Menopausal symptom
- ☐ Pregnancy

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
- ☐ Appendicitis
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Typhoid fever
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small pox
- ☐ Chicken pox
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal infection
- ☐ Epilepsy
- ☐ Mental disorder
- ☐ Eczema
- ☐ Drug dependency
- ☐ Emphysema
- ☐ Asthma
- ☐ H.I.V.
- ☐ AIDS
- ☐ ________________

Coffee, tea, caffeinated soft drinks (cups per day) ____________ Tobacco (packs per day) ____________

DO YOU HAVE A PERMANENT DISABILITY RATING? __________ Location ____________ Date received __________

rating percentage ________________

COMMENTS: ____

____

____

PAST HEALTH HISTORY

What surgeries have you had and/or fractures or broken bones, etc?

Type/When/Doctor/Remarks ____________________

____

List former serious accidents, injuries and/or falls: (auto, work, home, leisure, other)

What/When/Symptoms/Treatment/Results ____________________

____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/How long taken/Remarks ____________________

____

Do you wear orthotics, heel or sole lifts, in your shoes? ____________________

OCCUPATIONAL (PLEASE CIRCLE APPROPRIATE ANSWER & GIVE DETAILS BELOW)

Seated / Standing Work Bench / Desk Counter / Other

Job involves — lifting (how much weight) / bending / stooping / twisting / turning / carrying / walking / standing / other

Chair — Executive / Steno / Bench / Stool / Folding / Other ____________________

Shoes — High heels / boots / other ____________________

Do any work activities aggravate present main complaints? (describe) ____________________

Comments ____________________

____

LEISURE

Sedentary activities — TV/reading/card games/sewing/other (circle all applicable & describe how long) ____________________

____

Strenuous activities — Sports/exercise (type, frequency, length of time) Have you had to discontinue any activities?

describe ____________________

How would you grade your general stress level?

☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

Physical activity at work

☐ sedentary more than 50% of workday ☐ light manual labor ☐ manual labor ☐ heavy manual labor

General physical activity

☐ no regular program ☐ light exercise program ☐ strenuous exercise program

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signed: ____________________

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed ____________________ (Parent / Legal Guardian)

I UNDERSTAND and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature ____________________ Date ____________

Guardian or Spouse's signature ____________________ Date ____________

Information taken by ____________________ Date ____________

SYMPTOM SURVEY FORM

Patient____ M / F Date____________________

INSTRUCTIONS: **LEAVE THE QUESTION BLANK if the question does not apply to you.**
CIRCLE (1) for MILD symptoms (occurring once or twice a year).
CIRCLE (2) for MODERATE symptoms (occurring several times a month).
CIRCLE (3) for SEVERE symptoms (you are aware of it almost constantly)

GROUP ONE

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth-eyes-nose
5. 1 2 3 Pulse speeds after meals
6. 1 2 3 Keyed up – fail to calm down
7. 1 2 3 Cuts heal slowly
8. 1 2 3 Gag easily
9. 1 2 3 Unable to relax; startles easily
10. 1 2 3 Extremities cold, clammy
11. 1 2 3 Strong light irritates
12. 1 2 3 Urine amount reduced
13. 1 2 3 Heart pounds after retiring
14. 1 2 3 "Nervous" stomach
15. 1 2 3 Appetite reduced
16. 1 2 3 Cold sweats often
17. 1 2 3 Fever easily raised
18. 1 2 3 Tingling, Nerve-like pains
19. 1 2 3 Staring, blinks little
20. 1 2 3 Sour stomach frequent

GROUP TWO

21. 1 2 3 Joint stiffness after arising
22. 1 2 3 Muscle-leg-toe cramps at night
23. 1 2 3 "Butterfly" stomach, cramps
24. 1 2 3 Eyes or nose watery
25. 1 2 3 Eyes blink often
26. 1 2 3 Eyelids swollen, puffy
27. 1 2 3 Indigestion soon after meals
28. 1 2 3 Always seems hungry; feels "lightheaded" often
29. 1 2 3 Digestion rapid
30. 1 2 3 Vomiting frequent
31. 1 2 3 Hoarseness frequent
32. 1 2 3 Breathing irregular
33. 1 2 3 Pulse slow; feels irregular
34. 1 2 3 Gagging reflex slow
35. 1 2 3 Difficulty swallowing
36. 1 2 3 Constipation, diarrhea alternating
37. 1 2 3 "Slow starter"
38. 1 2 3 Get "chilled" infrequently
39. 1 2 3 Perspire easily
40. 1 2 3 Circulation poor, sensitive to cold
41. 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42. 1 2 3 Eat when nervous
43. 1 2 3 Excessive appetite
44. 1 2 3 Hungry between meals
45. 1 2 3 Irritable before meals
46. 1 2 3 Get "shaky" if hungry
47. 1 2 3 Fatigue, eating relieves
48. 1 2 3 "Lightheaded" if meals delayed
49. 1 2 3 Heart palpitates if meals missed or delayed
50. 1 2 3 Afternoon headaches
51. 1 2 3 Overeating sweets upsets
52. 1 2 3 Awaken after few hours sleep – hard to get back to sleep
53. 1 2 3 Crave candy or coffee in afternoon
54. 1 2 3 Moods of depression – "blues" or melancholy
55. 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56. 1 2 3 Hands and feet go to sleep easily, numbness
57. 1 2 3 Sigh frequently, "air
58. 1 2 3 Aware of "breathing heavily"
59. 1 2 3 High altitude discomfort
60. 1 2 3 Opens windows in closed room
61. 1 2 3 Susceptible to colds and fevers
62. 1 2 3 Afternoon yawner
63. 1 2 3 Get "drowsy" often
64. 1 2 3 Swollen ankles worse at night
65. 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66. 1 2 3 Shortness of breath on exertion
67. 1 2 3 Dull pain in chest or ` radiating into left arm, worse on exertion
68. 1 2 3 Bruise easily, "black and blue" spots
69. 1 2 3 Tendency towards anemia
70. 1 2 3 "Nose bleeds" frequent
71. 1 2 3 Noises in head, or "ringing in the ears"
72. 1 2 3 Tension under breastbone or feeling of "tightness", worse on exertion

GROUP FIVE

73. 1 2 3 Dizziness
74. 1 2 3 Dry skin
75. 1 2 3 Burning feet
76. 1 2 3 Blurred vision
77. 1 2 3 Itching skin and feet
78. 1 2 3 Excessive falling hair
79. 1 2 3 Frequent skin rashes
80. 1 2 3 Bitter, metallic taste in mouth in mornings
81. 1 2 3 Bowel movements painful or difficult
82. 1 2 3 Worrier, feels insecure
83. 1 2 3 Feeling queasy; headache over eyes
84. 1 2 3 Greasy foods upset
85. 1 2 3 Stools light-colored
86. 1 2 3 Skin peels on soles of feet
87. 1 2 3 Pain between shoulder blades
88. 1 2 3 Use laxatives
89. 1 2 3 Stools alternate from soft to watery
90. 1 2 3 History of gallbladder attacks or gallstones
91. 1 2 3 Sneezing attacks
92. 1 2 3 Dreaming, nightmare type bad dreams
93. 1 2 3 Bad breath (halitosis)
94. 1 2 3 Milk products cause distress
95. 1 2 3 Sensitive to hot weather
96. 1 2 3 Burning or itching anus
97. 1 2 3 Crave sweets

GROUP SIX

98. 1 2 3 Loss of taste for meat
99. 1 2 3 Lower bowel gas several hours after eating
100. 1 2 3 Burning stomach sensations, eating relieves
101. 1 2 3 Coated tongue
102. 1 2 3 Pass large amounts of foul-smelling gas
103. 1 2 3 Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hrs.
104. 1 2 3 Mucous colitis or
105. 1 2 3 Gas shortly after eating
106. 1 2 3 Stomach "bloating" after eating

GROUP SEVEN

(A)

107. 1 2 3 Insomnia
108. 1 2 3 Nervousness
109. 1 2 3 Can't gain weight
110. 1 2 3 Intolerance to heat
111. 1 2 3 Highly emotional
112. 1 2 3 Flush easily
113. 1 2 3 Night sweats
114. 1 2 3 Thin, moist skin `
115. 1 2 3 Inward trembling
116. 1 2 3 Heart palpitates
117. 1 2 3 Increased appetite without weight gain
118. 1 2 3 Pulse fast at rest
119. 1 2 3 Eyelids and face twitch
120. 1 2 3 Irritable and restless
121. 1 2 3 Can't work under pressure

(B)

122. 1 2 3 Increase in weight
123. 1 2 3 Decrease in appetite
124. 1 2 3 Fatigue easily
125. 1 2 3 Ringing in ears
126. 1 2 3 Sleepy during day
127. 1 2 3 Sensitive to cold
128. 1 2 3 Dry or scaly skin
129. 1 2 3 Constipation
130. 1 2 3 Mental sluggishness
131. 1 2 3 Hair coarse, falls out
132. 1 2 3 Headaches upon arising, wear off during day
133. 1 2 3 Slow pulse, below 65
134. 1 2 3 Frequency of urination
135. 1 2 3 Impaired hearing
136. 1 2 3 Reduced initiative

(C)

137. 1 2 3 Failing memory
138. 1 2 3 Low blood pressure
139. 1 2 3 Increased sex drive
140. 1 2 3 Headaches, "splitting or rending" type
141. 1 2 3 Decreased sugar tolerance

(D)

142. 1 2 3 Abnormal thirst
143. 1 2 3 Bloating of abdomen
144. 1 2 3 Weight gain around hips or waist
145. 1 2 3 Sex drive reduced or lacking
146. 1 2 3 Tendency toward ulcers, colitis
147. 1 2 3 Increased sugar tolerance
148. 1 2 3 Women: menstrual disorders
149. 1 2 3 Young girls: lack of menstrual function

(E)

150. 1 2 3 Dizziness
151. 1 2 3 Headaches
152. 1 2 3 Hot flashes
153. 1 2 3 Increased blood pressure
154. 1 2 3 Hair growth on face or body (female)
155. 1 2 3 Sugar in urine (not diabetes)
156. 1 2 3 Masculine tendencies (female)

(F)

157. 1 2 3 Weakness, dizziness
158. 1 2 3 Chronic fatigue
159. 1 2 3 Low blood pressure
160. 1 2 3 Nails, weak, ridged
161. 1 2 3 Tendency toward hives
162. 1 2 3 Arthritic tendencies
163. 1 2 3 Perspiration increase
164. 1 2 3 Bowel disorders
165. 1 2 3 Poor circulation
166. 1 2 3 Swollen ankles
167. 1 2 3 Crave salt
168. 1 2 3 Brown spots or bronzing of skin
169. 1 2 3 Allergies – tendency to asthma
170. 1 2 3 Weakness after colds, influenza
171. 1 2 3 Exhaustion – muscular and nervous
172. 1 2 3 Respiratory disorders

FEMALE ONLY

173. 1 2 3 Very easily fatigued
174. 1 2 3 Premenstrual tension
175. 1 2 3 Painful menses
176. 1 2 3 Depressed feelings before menstruation
177. 1 2 3 Menstruation excessive and prolonged
178. 1 2 3 Painful breasts
179. 1 2 3 Menstruate too frequently
180. 1 2 3 Vaginal discharge
181. 1 2 3 Hysterectomy/ovaries removed
182. 1 2 3 Menopausal hot flashes
183. 1 2 3 Menses scanty or missed
184. 1 2 3 Acne, worse at menses
185. 1 2 3 Depression of long standing

MALE ONLY

186. 1 2 3 Prostate trouble
187. 1 2 3 Urination difficult or dribbling
188. 1 2 3 Night urination frequent
189. 1 2 3 Depression
190. 1 2 3 Pain on inside of legs or heels
191. 1 2 3 Feeling of incomplete bowel evacuation
192. 1 2 3 Lack of energy
193. 1 2 3 Migrating aches and pains
194. 1 2 3 Tire too easily
195. 1 2 3 Avoids activity
196. 1 2 3 Leg nervousness at night
197. 1 2 3 Diminished sex drive

IMPORTANT

Please list below the five main physical complaints you have in order of their importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________