Dolan Chiropractic
6505 N. Prospect, Suite 700 Gladstone, MO 64119-1573
www.dolanchirokc@gmail.com **(816) 454-3399 Fax (816) 454-3012**

PATIENT INFORMATION

Whom may we thank for referring you?_____ Date_____

Patient_____ Age_____ Birthdate_____ Sex *F or M* S.S.# _____

Address_____ City_____ State_____ Zip_____

SIngle Married Widowed Separated Divorced Occupation_____

Phone Numbers Home_____ Cell_____Texting: *Yes or No* Work_____

Email:_____

Spouse's Name_____ Occupation _____

Phone Number Cell_____Texting: *Yes or No* Work_____

INCASE OF EMERGENCY, WHOM TO CONTACT

Name_____ Relationship_____ Phone_____

PATIENT CONDITION

Reason for Visit_____

Is the condition due to an accident? _____ If so what type of accident? *Auto Work Home Other*

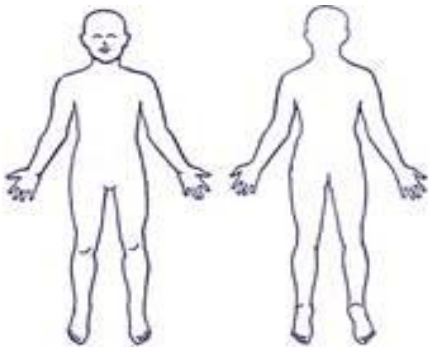
To whom have you made a report of your accident? *Auto Insurance Employer Worker Comp. Attorney*

Name of Attorney (if applicable) _____

When did your symptoms appear? _____

Is this condition getting progressively worse? *Yes or No*

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: *Sharp Dull Throbbing Numbness Aching Shooting*
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go?_____

Does it interfere with your *work sleep daily routine recreation*

Please list activities or movements that are painful to perform_____

Have you seen other doctors for your condition?_____If so, when?_____Did you receive x-rays or any scans?_____
Name and address of that doctor_____

Are you pregnant? *Yes or No* Due Date_____

HEALTH HISTORY

PAST:

Family Diseases (list Father(F), Mother(M), Sister(S), Brother(B) and type of disease):

Arthritis:____Type:_____ Autoimmune Disease:____Type:_____Cancer:____Type:_____

Diabetes:_____Type:_____ Heart Disease:_____ Type:_____ Stroke:____ Type:_____

Other_____

Please mark to indicate if you have had any of the following:

AIDS/HIV	*Alcoholism*	*Allergy Shots*	*Anemia*	*Anorexia*
Appendicitis	*Arthritis*	*Asthma*	*Bleeding Disorders*	*Breast Lump*
Bronchitis	*Bulimia*	*Cancer*	*Cataracts*	*Chemical Dependency*
Chicken Pox	*Diabetes*	*Emphysema*	*Epilepsy*	*Fractures*
Glaucoma	*Goiter*	*Gonorrhea*	*Gout*	*Headaches*
Heart Disease	*Hepatitis*	*Hernia*	*Herniated Disk*	*Herpes*
High Cholesterol	*Kidney Disease*	*Liver Disease*	*Measles*	*Migraines*
Miscarriage	*Mononucleosis*	*Multiple Sclerosis*	*Mumps*	*Osteoporosis*
Pacemaker	*Parkinson's*	*Pinched Nerve*	*Pneumonia*	*Polio*
Prostate Problems	*Prosthesis*	*Psychiatric Care*	*Rheumatoid Arthritis*	*Rheumatic Fever*
Scarlet Fever	*Stroke*	*Suicide Attempt*	*Thyroid Issues*	*Tonsillitis*
Tuberculosis	*Tumors/growths*	*Typhoid Fever*	*Ulcers*	*Vaginal Infections*
Venereal Disease	*Whooping Cough*	*other*_____		

PRESENT:

C. Allergies (Medication or other):

_____

D. Medications & Vitamins (Name, dosages, & start date):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

E. Surgeries (Type of procedure & When):

_____ _____

_____ _____

F. Lifestyle and Social Activities: Circle One for each item

Alcohol - *Daily Weekly Occasionally Never*

Caffeine Drinks and Products - *Daily Weekly Occasionally Never*

Exercise - *Daily Weekly Occasionally Never*

Tobacco - *Daily Weekly Occasionally Never*

Are you a Current smoker? *Yes or No* If no, are you a Former tobacco user? *Yes or No*

When did you quit? _____ How did you quit?_____

Office Use Only

Height_____ Weight_____ Blood Pressure_____ Pulse_____ X-Ray #_____