Advanced Chiropractic Center
Dr. Giuseppe Romano, D.C.

Today Date: ________________

PATIENT INFORMTION

Name: ____

Address: ____

City: ____________ State: ___________ Zip: _____________

Home Phone: _______________________________________

Cell Phone: ____

Work Phone: _______________________________________

E-mail: ____

Sex: ✷ Male ✷ Female

Height: ____ Ft ____In Weight: ____lbs

Marital Status: ______________________________________

Social Security #: ____________________________________

Date Of Birth: _______________________________________

Occupation: ____

Employer/School: ___________________________________

Notify In Case of Emergency: __________________________

____

Relationship To Patient: _____________________________

Whom May We Thank For Referring You?: _______________

____

INSURANCE INFORMATION

Insurance Carrier: __________________________________

Address: ____

City: ____________ State: __________ Zip: _____________

Telephone #: _______________________________________

Policy #: ____

Effective Date: ______________________________________

Policyholder's Name: _______________________________

Relationship to Patient: _____________________________

ACCIDENT INFORMTION

Is Condition Due To An Accident? : ✷ Yes ✷ No

Type Of Accident: ✷ Auto ✷ Work ✷ Home ✷ Other

Date Of Accident: ___________________________________

To Whom Have You Reported This Accident?

✷ Auto Insurance ✷ Worker Compensation

✷ Employer ✷ Other: ____________________

ATTORNEY INFORMTION (if applicable)

Attorney Name: ____________________________________

Address: ____

City: ____________ State: __________ Zip: _____________

Telephone #: _______________________________________

Advanced Chiropractic Center
Dr. Giuseppe Romano, D.C.

Name: ______________________________ Date of Birth: ____________________

/// STABBING   XXX BURNING   *** TINGLING   OOO NUMBNESS   +++ ACHING

RIGHT   LEFT   RIGHT

Pain Level 0 1 2 3 4 5 6 7 8 9 10

NONE   MOD   SEVERE

1. When Did your problem begin? ____/_____/______

2. Please describe your current condition and how the problem began: ______________________

   ____

3. How long have you had this problem?: ______________________________________

4. How would you describe your pain?: ✹ Sharp ✹ Soreness ✹ Throbbing ✹ Tingling ✹ Dull ✹ Stiffness ✹ Spasm ✹ Burning ✹ Ache ✹ Weakness ✹ Numbness ✹ Shooting

5. How often is the pain present during your waking day?:

   Pain Level 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Since your problem began, is your pain: ✹ Getting Better ✹ Getting Worse ✹ Staying The Same

7. What makes your problem worst?:

✷ Nothing ✷ Walking ✷ Standing ✷ Sitting ✷ Lying Down ✷ Moving ✷ Resting

8. If your problem affecting your ability to work or do other routine daily activities?:

✷ No Effect ✷ Affects Work/Activities Greatly ✷ Affects Work/Activities Somewhat

Patient or Guardian Signature: ____ Date: ____/_____/_____