Dr. Marianna Fuscaldo, BSc, DC

Date _____ /_____ /_____

First Name _____ Last Name _____ Date of injury (if applicable) _____ /_____ /_____

Address _____ City/Province _____ Postal Code _____

Home Phone (____) _____ Business Phone (____) _____ Cell Phone (____) _____

Occupation _____ Care Card # _____ Date of Birth _____ / _____ / _____

Emergency Contact

Name _____ Relationship to you _____

Home Phone (____) _____ Business Phone (____) _____ Cell Phone (____) _____

Medical Doctor

Name _____ Phone (_____) _____ Location _____

When was your last appointment with your MD? _____ / _____ / _____ When was your last physical exam? _____ / _____ / ____

Previous Chiropractic Treatment

Reason(s) for care _____ Did you find him/her helpful with your condition? Y or N

Please list other health care professional(s) you are currently under the care of and provide the reason:

Name _____ Reason _____

Name _____ Reason _____

History

How would you rate your overall health? Poor Average Above Average Very Good

How much sleep do you average a night? _____ Height _____ Weight _____

What kind of exercise and how much per week do you get? _____

Please list any vitamins or supplements you take _____

Please list any allergies you are aware of _____

Please list any relevant X-rays taken and the date Part of the body _____ Date _____ /_____ /_____

Does anyone in your family suffer from any of the following? (please circle)

Strokes Migraines Cancer Depression Diabetes Heart Disease Liver Disease Low Back Pain High Blood Pressure

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Consent to Release/Obtain Information

I hereby give permission to Dr. Marianna Fuscaldo DC, to release information and/or obtain information from health care professionals as named above. I understand that any communication will be held as private and confidential and will be for the sole purpose of providing me with the best and most efficient care possible.

Patient signature _____ _____ /_____ /_____

Witness _____ _____ /_____ /_____

Dr. Marianna Fuscaldo, BSc, DC

Date _____ /_____ /_____

Reasons for seeking care:

_____

_____

_____

_____

_____

_____

Show area(s) of pain or unusual feeling.

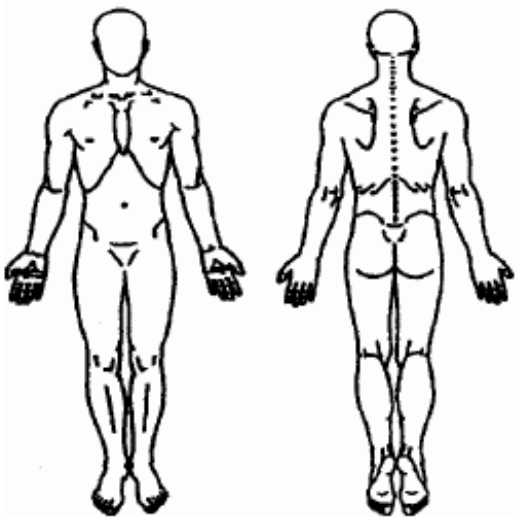
What makes it better?

_____

What makes it worse?

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

Please CHECK all conditions or symptoms that apply, both current and past conditions.

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss/lack of sleep
Numbness, pain or tingling
Nervousness
Loss of weight
Depression

MUSCLES AND JOINTS
Stiff neck
Back ache
Swollen joints
Painful tail bone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness/loss of strength

EARS, EYES, NOSE, THROAT
Blurred vision
Failing vision
Double vision
Eye pain
Deafness
Earache
Ring/buzz/noise in ears
Asthma
Frequent colds
Sinus infection
Slurred/other speech problems
Difficulty swallowing

RESPIRATORY
Chronic cough
Spitting up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Bleeding disorder
High blood pressure
Pain over heart
Stroke
Hardening of the arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease

GENITOURINARY
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

SKIN
Rashes, itching
Bruise easily
Dryness
Hives (allergy)

GASTROINTESTINAL
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Gallbladder trouble
Ulcer
Diabetes

FOR WOMEN
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Have you ever taken birth control? Y or N
If yes, are you currently taking? Y or N
Pregnancies _____ # Children _____

Have you had any fractures? Y or N

Have you ever been in a car accident? Y or N

Have you ever been hospitalized? Y or N

Are you a smoker? Current Past Never

Alcohol intake per week _____

Do you take medication regularly? Y or N

If yes, what? _____

Have you ever been diagnosed with:
HIV Y or N
Hepatitis Y or N
Cancer Y or N