

AZZOLINO CHIROPRACTIC NEUROLOGY GROUP

Outline Procedure for New Patients

Step One: All new patients are requested to fill out a personal health questionnaire prior to their appointment.

Step Two: Your consultation with a doctor to discuss your health problems.

Step Three: Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if Chiropractic care is appropriate for your condition.

Step Four: You will be advised if there is the need of any additional procedures such as X-rays, MRI, & CAT Scan.

Step Five: If your case requires immediate attention, treatment will be administered.

Step Six: You will be advised as to a time you can return for your "Report of Findings" so that the Doctor will inform you as to your examination results and whether or not your case has been accepted.

You will be informed of specific recommendations in regards to your condition.

Step Seven: If appropriate, your treatment plan will begin following your "Report of Findings."

Confidential Patient Information

Name _____ Called Name _____ Date _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Date of Birth _____ Age _____

Referred By: Patient (name) _____ Physician (name) _____
 Therapist (name) _____

Work Status: Employed Retired Disabled Full-time Student Part-time Student

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Social Security # _____ Drivers License # _____

Marital Status Married Single Divorced Widow Spouse/Partner's Name: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional wellbeing (Comprehensive Care). Chiropractic Neurology offers some of the latest advanced procedures for optimizing your nervous system function.

The Azzolino Chiropractic Neurology Group stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care Corrective Care Comprehensive Care Would like to discuss options with the doctor

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The practitioners at the Azzolino Chiropractic Neurology Group do not participate in any HMO/PPO organizations. I understand that the Doctor's Office will prepare any necessary forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of services.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

Name _____ Hm.Phone _____ Wk. Phone _____

Complaint # 2: _____ When did you first notice this condition? _____

Did it begin Immediate or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms? Constant Frequent (75% of day) Often (50%)
 Seldom (25%) Rarely (less than 25%) _____

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1(minimal) and 10 (severe/excruciating pain) _____

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Is your pain Deep or Superficial

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling Numbness
 Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

- | | | | | |
|--|----------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Sitting ___ min | <input type="checkbox"/> Lying | <input type="checkbox"/> Lifting _____ lbs. | <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Hot or Cold |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Pushing | <input type="checkbox"/> Gripping | <input type="checkbox"/> Mental Activities | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Pulling | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Bright Lights | <input type="checkbox"/> _____ |

Please indicate what helps you to relieve the pain.

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Lying | <input type="checkbox"/> Walking | <input type="checkbox"/> Rest | <input type="checkbox"/> Medications _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Heat or Cold | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Complaint # 3 _____ When did you first notice this condition? _____

Did it begin Immediate or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms? Constant Frequent (75% of day) Often (50%)
 Seldom (25%) Rarely (less than 25%) _____

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1(minimal) and 10 (severe/excruciating pain) _____

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Is your pain Deep or Superficial

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling Numbness
 Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

- | | | | | |
|--|----------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Sitting ___ min | <input type="checkbox"/> Lying | <input type="checkbox"/> Lifting _____ lbs. | <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Hot or Cold |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Pushing | <input type="checkbox"/> Gripping | <input type="checkbox"/> Mental Activities | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Pulling | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Bright Lights | <input type="checkbox"/> _____ |

Please indicate what helps you to relieve the pain.

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Lying | <input type="checkbox"/> Walking | <input type="checkbox"/> Rest | <input type="checkbox"/> Medications _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Heat or Cold | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Past Medical History

Please include any of your previous conditions. If possible include Dates, Diagnosis, Treatment Received and any Residuals you still suffer from.

Utero, Birth, and Infancy:

Was your mother healthy when you were in utero? No Yes _____

Did she smoke or consume alcohol? No Yes _____

Where were you born? _____

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process? No Yes _____

Were you vaccinated? No Yes _____

Did you have normal neurological, structural, emotional, and social development? Yes No _____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development?

Yes No _____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Teens (ages 13-19)

Did you have normal neurological, structural, emotional, social, and academic development?

Yes No _____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: What age did you start your menses? ____ Regular Irregular

Twenties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: Menopausal symptoms none yes _____

Fifties

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: Menopausal symptoms none yes _____

Sixties

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Seventies

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Eighties

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Nineties

	Excellent	Good	Average	Below Average	Poor	
Mental Abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Family History

Mother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Father Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Children: Ages _____ Any health conditions? _____

Maternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Maternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Have any of your family members have ever suffered from any of the following conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorders _____ | <input type="checkbox"/> Depression/Mental Illness _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Autoimmune Diseases _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> _____ |

Medications Please list your current medications and what taken for.

Vitamins and Minerals Please list your current supplements and by whom prescribed.

Habits

Cigarettes none How much per week? _____ Cigars none How many per week? _____

Alcohol none How many drinks per week? _____ Type of alcohol _____

Coffee none How many cups per week? _____

Recreational Drugs none Types _____ Frequency _____ Years of Usage _____

Exercise none Hours/Days per week _____ Types _____

Water none Glasses per day _____

Soft Drinks none Amount per week _____ Types _____

Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? Hours desired per night?

Meals per days _____ What type of foods do you eat? _____

Do you consider your diet healthy? Yes No _____

DATE OF LAST:

Physical Examination: _____ By Whom? _____ Results _____
Blood Work: _____ By Whom? _____ Results _____
Bone Density Study _____ results _____ Mammogram _____ results _____
Pelvic Exam _____ results _____ Self Breast Exam _____ Regularity _____
PSA level _____ results _____ Digital Prostate Examination _____ results _____
Chest X-rays _____ results _____ EKG _____ results _____ Echocardiogram _____ results _____
Spinal X-rays _____ By Whom? _____ Where are they located? _____
MRI / CAT Scan _____ results _____ Where are they located? _____
Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you HAVE.

- Mental Disorders Diabetes Pneumonia Infective Diseases_____
- Epilepsy Anemia Tuberculosis Fungal Infection_____
- Tumors Glaucoma Hepatitis_____ Herpes_____
- Alcoholism Heart Disease Thyroid Disease Arthritis
- Drug Addiction Rheumatic Fever Parasites Autoimmune Disease
- Cancer Scarlet Fever Venereal Infection _____

NERVOUS SYSTEM

- Depression
- Memory loss/Confusion
- Dizziness
- Fainting
- Convulsions
- Numbness
- Weakness
- Poor Balance/Coordination
- Twitches/Tremor
- Cold/Tingling Extremities
- Sleeping Difficulties
- Headaches

EENT

- Vision Problems
- Flashing Lights
- Black Spots
- Blurriness
- Hearing Loss
- Ringing in Ears
- Swallowing Difficulty

C-V

- Chest Pain
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

GI

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Frequent Diarrhea
- Frequent Constipation
- Hemorrhoids
- Black/Bloody Stools
- Digestive Problems
- Abdominal Cramping
- Gas/Bloating After Meals
- Heartburn
- Weight Problems
- Gall Bladder Problems
- Liver Problems

GU

- Bladder Trouble
- Painful Urination
- Excessive Urination
- Incontinence
- Discolored Urination

MUSCULOSKELETAL

- Jaw Pain
- Difficulty Chewing
- Face Pain
- Neck Pain
- Arm/Elbow Pain
- Wrist/Hand Pain
- Mid Back Pain
- Lower Back Pain
- Thigh/Knee Pain
- Ankle/Foot Pain
- Difficulty Walking
- Leg/Arm Fatigue

REPRODUCTIVE

- Erectile Difficulties
- Sexual Dysfunction
- Menstrual Irregularity
- Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? Yes No
Do your stools float or sink

How many times a day do you urinate? _____ Is this consistent? Yes No _____
Do you experience any urgency, dribbling, incontinence? _____