O'Malley Chiropractic Health Center, LLC
78 Beaver Road Suite 1A
Wethersfield CT, 06109

Name:_____

Address:_____

City: _____**State**: _____**Zip**:_____

Home Phone: ____-____-_____ **Work Phone**: ____-_____-_____**Cell Phone**: ____-_____-_____

Email Address: _____ **Gender**: Male or Female

Occupation (include company/town):_____

Date of Birth: _____ **Social Security #:** _____-_____-_____

Relationship Status: Married/Single/Divorced/Widowed/Partnered

Are you pregnant? ☐ Yes ☐ No
Do you have children? Yes or No If so, how many?_____
Do you smoke? ☐ Yes ☐Never ☐Former Smoker: When did you quit? _____
Do you drink alcohol? ☐ Yes ☐No
Do you drink caffeine? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐No
Do you have a pacemaker? ☐Yes ☐No
Have you ever had chiropractic care before outside of our office? ☐ Yes or ☐No
If so, when, where and why? _____
Were X-rays taken? ☐ Yes or ☐No If so, where and when? _____
Who is your Primary Care Physician? _____
What town does he/she practice in? _____ When was your last physical? _____
How did you hear about our office? _____

Check any **Allergies**:
☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen
☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ **None**
☐ Other: _____

Check any **Surgeries** along with the **date** you had the surgery:
☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ **None**
☐ Other: _____

Check **ALL Past/Current Medical History** conditions:
☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain
☐ Depression☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/ Vision Problems ☐ Fainting ☐ Fatigue
☐ Foot Pain ☐ Genetic Spinal Condition☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Cholesterol
☐ High Blood Pressure ☐ Hip Pain ☐ HIV/AIDS ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain
☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain
☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio☐ Prostate Problems ☐ Seizures ☐ Shoulder Pain
☐ Significant Weight Change ☐ Spinal Cord Injury☐ Sprain/ Strain ☐ Stroke/ Heart Attack ☐ Thyroid problems

☐ Other: _____

Please list all medications/supplements you are currently taking below:

1. _____ Dosage: _____ Reason: _____
2. _____ Dosage: _____ Reason: _____
3. _____ Dosage: _____ Reason: _____
4. _____ Dosage: _____ Reason: _____
5. _____ Dosage: _____ Reason: _____
6. _____ Dosage: _____ Reason: _____
7. _____ Dosage: _____ Reason: _____
8. _____ _____Dosage: _____ Reason: _____
9. _____ Dosage: _____ Reason: _____
10. _____ Dosage: _____ Reason: _____

Do you have any allergies to medications? ☐Yes ☐No
If so, please list below:
_____

Check your **Family History:**

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition
☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio
☐ Prostate Problems ☐ Stroke/Heart Attack

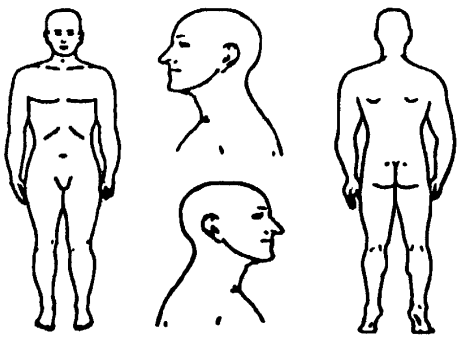
Please list all family members who had/has any of the problems above:

Example: Paternal Grandmother – High blood pressure

_____
_____

Have you had any auto or worker's compensation related accidents? ☐ Yes ☐No
If so, please list date and describe: _____
_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



O'Malley Chiropractic Health Center, LLC

PATIENT NAME: _____ **DATE:** _____

Where is your FIRST problem area? (Example "neck" or "low back" etc.) (Right/Left/Both Sides/Center?)

_____

Please give a date when the most recent episode of the pain came on

_____/_____/_____

Please describe how this issue came on (Example: "I was exercising"). If you are unsure, please indicate the activity you suspect most likely caused the problem: _____

_____

What activities cause the pain to increase? Please check all that apply ☐ Baking ☐ Bathing ☐ Bending
☐ Care of others/pets ☐ Caring for children ☐ Carrying objects ☐ Cleaning ☐ Climbing stairs ☐ Cooking/cleaning
☐Crouching/squatting ☐ Desk work ☐ Doing hobbies ☐ Dressing ☐ Driving ☐ Eating ☐ Exercise/sports
☐ Gardening ☐ General mobility ☐ Getting places ☐ Grasping objects ☐ Hearing ☐ Hiking
☐ Holding onto objects ☐ Housework ☐ Jogging ☐ Keeping balance ☐ Knitting ☐ Leaning ☐ Lifting
☐ Lying down ☐ Moving joint(s) ☐ Mowing ☐ Personal hygiene/grooming ☐ Pushing/pulling with hand
☐ Raising the arm ☐ Reaching motions ☐ Reaching out/up/down ☐ Reading ☐ Running ☐ Sewing
☐ Sexual activity ☐ Shopping ☐ Sitting ☐ Sleeping ☐ Standing ☐ Turning ☐ Turning the head ☐ Twisting
☐ Typing ☐ Using the phone ☐ Walking ☐ Watching TV ☐ Working ☐ Yard work

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Please rate your pain on a scale of 1 to 10. (0= no pain and 10= excruciating pain)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the nature of your symptoms:
☐ Burning ☐ Dull ache ☐ Numb ☐Radiating to: _____ ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Tight ☐ Tingling ☐ Throbbing

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What are your expectations for consulting with the Doctor?
☐ Become pain free ☐ Explanation of condition ☐ Learn how to care for my condition on my own
☐ Reduce Symptoms ☐ Resume normal daily activities

What makes the pain better?
☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice ☐ Massage ☐ Nothing works ☐ Pain Medicine
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching
How do your symptoms affect your ability to perform daily activities? (0= no effect and 10= no possible activities)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

PATIENT SIGNATURE:_____**Mark E. O'Malley, D.C.** _____**Date:**_____