

SKYE CHIROPRACTIC

Dr. Renee A. Tornatore

Dr. Rodney Q. Wisdom

Full Name _____ Today's Date _____ S.S.# _____ Age _____

Date of Birth _____ Address _____ City _____ State _____ Zip _____

Height _____ Weight _____ Race _____ Occupation _____ Where Employed _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse Name _____ Where Employed _____

[] Married [] Single [] Divorced [] Separated [] Widowed

An understanding of your health history will help us to determine appropriate care.

Review of Systems:

1. Do you have skin, hair or nail problems? Yes No _____

2. Do you have mouth and/or throat problems? Yes No _____

3. Do you have nose and/or sinus problems? Yes No _____

4. Do you have ear problems? Yes No _____

5. Do you have eye problems? Yes No _____

6. Do you have chest or lung (breathing) problems? Yes No _____

7. Do you smoke? Yes No Cigarettes per day _____ How Long? _____

8. Do you have heart and/or blood vessel problems? Yes No _____

9. Do you have blood or lymph node problems? Yes No _____

10. Do you have digestive problems? Yes No _____

11. Do you have genital problems(e.g.,prostate, testicular, vaginal)? Yes No _____

12. Do you have urinary (including kidney or bladder) problems? Yes No _____

13. **FEMALES**-Have you had menstrual problems? Yes No _____

Have you ever taken birth control pills? Yes No For How Long? _____

Is there any chance that you are currently pregnant? Yes No _____

Do you have any breast problems? Yes No _____

14. Do you have any nervous system diseases and/or mental health problems? Yes No _____

15. Do you have any gland and/or hormone problems? Yes No _____

16. Do you have allergy or immunity problems? Yes No _____

17. Do you have any muscle, tendon or ligament problems? Yes No _____

18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? Yes No _____

Past History

19. List any diseases that you have had in the past, including childhood diseases: _____

20. Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc.: _____

21. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No If yes, describe accident including date of accident: _____

22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth): _____

Date: _____

Date: _____

Date: _____

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Full Name: _____

23. Have you ever been hospitalized for any reason other than surgery? Yes No _____
24. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____
25. Have you ever had cancer? Yes No If Yes describe: _____

Family History

26. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases or conditions)?
 Yes No _____

Social History

27. In what position do you usually sleep, and how well? _____
28. Do you exercise on a regular basis? Yes No How? _____
29. How do you spend you spare time (hobbies, etc)? _____
30. Your Diet is: Balanced Fair Poor Excessive Restricted
31. Do you use: Caffeine Tobacco Nicotine Recreational Drugs Alcohol
32. Please describe your work:
Type: Professional Physical Labor Driver Clerical Factory Homemaker
Physical Demands: Heavy Moderate Mild Sedentary
Stress Level: High Medium Low

Additional History

33. If there is any information about your health history that was not requested, please fill it in below: _____
34. Please describe your current complaint. In other words, what brought you here? Is it related to an accident or injury? _____
35. Who is your Medical Doctor? _____
36. Have you ever seen a Chiropractor before? Yes ___ No ___ If yes, how long ago? _____
37. Have you ever seen a Physical Therapist before? Yes ___ No ___ If yes how long ago? _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____
Authorizing Care

NOTICE TO PATIENTS

We work hard to provide the best, most efficient and affordable chiropractic healthcare. In order to provide our high quality of service and efficiency we must keep our costs down. We do work for you. However, we do reserve the right to dismiss you as a patient if you miss more than three (3) appointments without prior notice. This arrangement will allow our office to maintain a level of service to each and every patient, as each patient counts on our quality and efficiency of service and care.

Requests by patients for X-ray(s) will be process in 24 hours. The patient is responsible for their X-ray(s) once they are released from Skye Chiropractic, LLC until they are returned.