

WELCOME TO THE OFFICE OF ANTHONY FIORINI, DC, LLC

ohio-posture-control.com

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Birth date: _____ Age: _____ Male/ Female SS#: _____

Primary Care Physician Name: _____

Emergency Contact Person: _____ Phone: _____

How did you hear about us or who referred you? _____

Reason for seeking chiropractic care? _____

Health History

In order of importance, describe any health problems including how long you have had them:

1. _____
2. _____
3. _____
4. _____

When was the first time you noticed this problem(s)? _____

Please describe how this problem interferes with your work and/or personal life:

Home activities affected: _____

Work activities affected: _____

Recreational activities affected: _____

Rest or Sleep affected: _____

What had this problem(s) been keeping you from doing that you really like to do? _____

Are you under the care of any other doctor? **Y N** If yes, the conditions being treated for:

Have your health problems been: **Improving Worsening Staying the same**

Please describe anything you do that improves your condition, or worsens it: _____

List any current medications: _____

List any current vitamins or supplements: _____

List any past surgeries and dates: _____

List any past accidents or injuries and dates: _____

Personal and Family History

Occupation: _____ Employer’s Name & Address: _____

Work Phone: _____ Ext: _____ Work Duties: _____

Marital Status: S M W D Insured SS#: _____ Ins. Birth date: _____

Spouse’s Name: _____ Spouse’s Health Status: _____

Children ages & health status : _____

Are you pregnant? Yes No

Chiropractic History

Have you ever been to a chiropractor before? Y / N If yes, Doctor’s name: _____

Date of last chiropractic visit: _____ Reason for care: _____

Date of last chiropractic x-rays: _____ How long were you under care? _____

Are other family members under chiropractic care? Y/ N Who? _____

Do you have a wellness practitioner?

What are you doing to keep yourself healthy? _____

Wellness Commitment

At Fiorini Chiropractic, we are dedicated toward the goal of lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We ask for your cooperative commitment. Based on a scale of 10% or 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%---20%---30%---40%---50%---60%---70%---80%---90%---**100%**

The purpose of chiropractic care is not to treat diseases or conditions, or to suppress symptoms, but rather to make your body function better by reducing and removing spinal nerve stress (**subluxations**).

A **vertebral subluxation** is a misalignment of your spinal column or related structures that can affect your nervous system and overall functions of the body. **Subluxations** can cause dis-ease or loss of proper body function and loss of proper adaptation.

Your chiropractor has spent years studying how to locate and correct this destructive condition by first analyzing your spine using various diagnostic methods. Second, we adjust your **subluxations** by using specialized techniques. When your spine and nervous system are free from **subluxations**, your body will function and adapt to internal and external stressors more efficiently.

No matter what condition(s) you may have been diagnosed with, or what symptoms your body may be expressing, you always need a body free of **subluxations**. We do not prescribe medications or surgery. If you wish to decrease or stop medications, you should discuss it with your MD. If during the course of your care we encounter unusual findings, we will let you know. We will cooperate with other healthcare professionals and you in your goals.

Our mission is to create a nurturing environment where we eliminate a major interference to the expression of your physical, emotional and spiritual health and healing –**vertebral subluxations**- so that your body can naturally adapt, heal and grow.

I _____, have read and fully understand the above statements.

Date: ____/____/____

Pain Drawing

Name: _____

Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching
++++

Numbness
===

Pins & needles
OOO

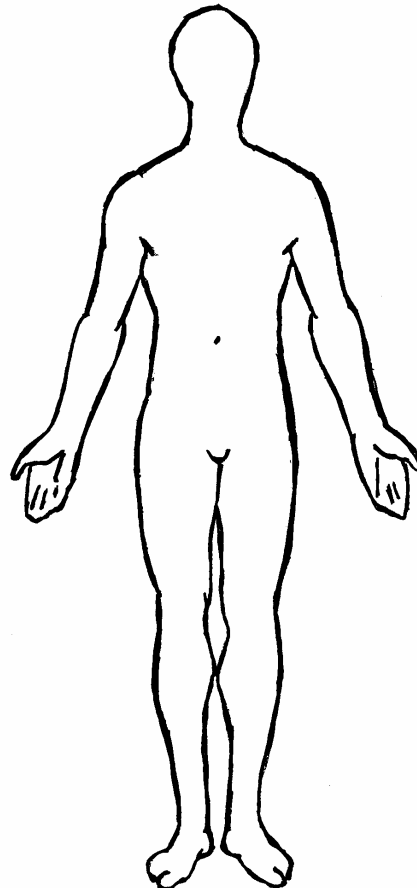
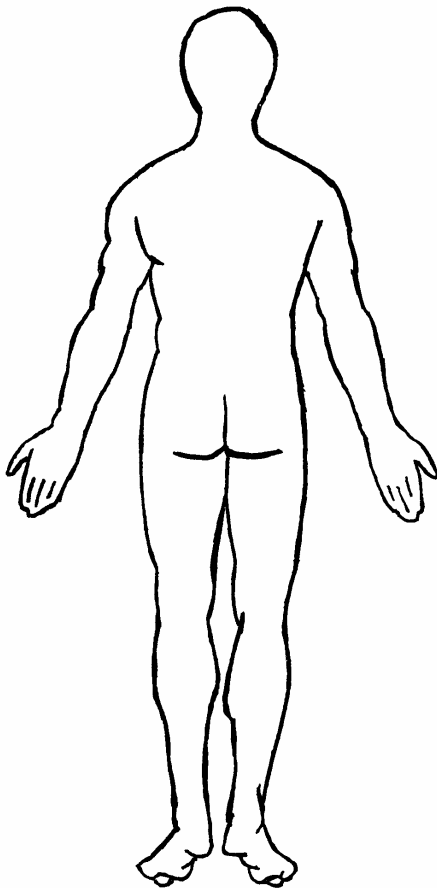
Burning
xxx

Stabbing
///

Other
....

FRONT

BACK



0 = absolutely pain free 10 = worst pain

0 1 2 3 4 5 6 7 8 9 10