

PATIENT INFORMATION

Full Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex ☐ Female ☐ Male ☐ Other

SS # _____ Marital Status ☐ S ☐ M ☐ D ☐ W Spouse Name _____

Mobile Phone _____ Email _____

Street Address _____

City _____ State _____ ZIP _____ Occupation _____

How did you hear about us? ☐ Google ☐ Facebook / Instagram ☐ Friend / Family ☐ Existing Patient
☐ Doctor / Provider ☐ Attorney ☐ Apple ☐ Other

YOUR CONDITION

Main reason for your visit today _____

How long has this problem existed? _____ Had this before? ☐ Yes ☐ No

CURRENT SYMPTOM SNAPSHOT

Current intensity (0 = none, 10 = worst) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much of the day? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent Trend ☐ Worse ☐ Better

How would you describe your symptoms?	What tends to make it worse?
☐ Dull ache	☐ Sitting
☐ Burning	☐ Standing
☐ Tingling	☐ Bending / lifting
☐ Throbbing	☐ Certain movements
☐ Sharp	☐ Weather
☐ Tightness	☐ Stress
☐ Numbness	☐ Standing
☐ Stabbing	☐ Walking / activity
☐ Radiating	☐ Poor sleep
☐ Shooting	☐ Repetitive motions
	☐ Other

WHAT YOU'VE TRIED & WHAT YOU WANT BACK

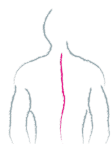
What have you already tried for this problem?

☐ Medication	☐ Physical Therapy	☐ Surgery	☐ Massage	☐ Acupuncture
☐ Injections	☐ Chiropractic	☐ Stretching	☐ Heat / Ice	☐ Nothing

What does this interfere with?

☐ Walking / running	☐ Standing	☐ Sitting	☐ Driving	☐ Sleeping
☐ Exercise	☐ Working	☐ Household chores	☐ Personal care	☐ Social activities

What would you most like to be able to do again?



PAIN MAP

Mark the areas where you feel symptoms.

Mark symptoms directly on the figures.

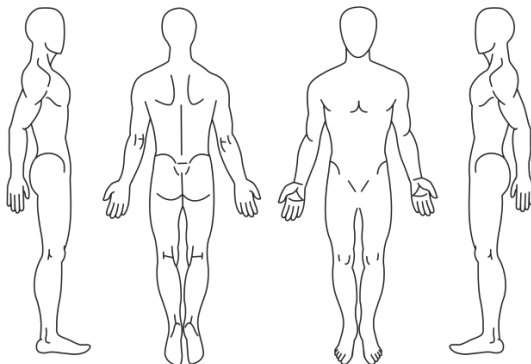
P = Pain

N = Numbness

T = Tingling

B = Burning

C = Cramping



HEALTH QUESTIONS

Are you pregnant?

☐ Yes ☐ No ☐ Unsure

Any implant, pacemaker, or electronic device?

☐ Yes ☐ No ☐ Unsure

Recipient of an organ transplant?

☐ Yes ☐ No ☐ Unsure

Taking blood thinners or statins?

☐ Yes ☐ No ☐ Unsure

If yes, identify device / condition: _____

MEDICATIONS & HISTORY

Allergies _____

Current medications (please list all medications)

Surgeries, major injuries / traumas, or hospitalizations (include approximate dates)

PAST MEDICAL HISTORY

Check all that apply.

- | | | | |
|--|--|--|--|
| ☐ HIV / AIDS | ☐ Depression | ☐ High blood pressure | ☐ Reproductive issues |
| ☐ Alcoholism | ☐ Diabetes | ☐ High cholesterol | ☐ Ringing in ears |
| ☐ Anxiety | ☐ Digestive issues | ☐ Hip issues | ☐ Scoliosis |
| ☐ Arteriosclerosis | ☐ Dizziness | ☐ Immune issues | ☐ Shoulder issues |
| ☐ Arthritis | ☐ Elbow / Hand / Wrist issues | ☐ Joint pain | ☐ Stroke |
| ☐ Aortic aneurysm | ☐ Endocrine issues | ☐ Knee pain | ☐ Thyroid problem |
| ☐ Asthma / Allergies | ☐ Foot / Ankle issues | ☐ Memory loss | ☐ TMJ issues |
| ☐ Back pain | ☐ Gout | ☐ Lymphatic issues | ☐ Urinary issues |
| ☐ Cardiovascular issues | ☐ Headaches / Migraines | ☐ Multiple sclerosis | ☐ Other _____ |
| ☐ Cancer | ☐ Heart disease | ☐ Neck pain | |
| ☐ Circulation issues | ☐ Hepatitis | ☐ Osteoporosis | |

CONSENT & COMMUNICATION

I consent to allow Dr. Dalfino to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for treatment and a course of care. The questions on this form have been answered completely and truthfully to the best of my knowledge. Our office provides an appointment reminder service by email and SMS and may also communicate with you from time to time.

Signature _____

Date _____