Confidential Patient History Form **Date:**_____

Name_____ Home Phone_____
I prefer to be called_____ Cell Phone _____
Address_____ Work Phone_____
_____ Email_____
_____ Date of Birth_____ Age_____
Sex □ **Male** □ **Female** Height ____' ____" Weight _____lbs
Occupation_____ Marital Status_____
Employer_____ No of Children_____

If minor, name of parent or guardian_____
Who should we contact in case of an emergency?_____
Relation _____ Phone_____
Primary Care Physician_____ City_____
Who may we thank for referring you to this office?_____
Have you ever been to a chiropractor before? □ **YES** □ **NO** If so, whom?_____

1. Reason for visit *(Please circle)*: **sport injury, auto accident (□ My Fault, □ Not My Fault) work accident, acute trauma, chronic condition or other:**_____
2. If this visit is due to pain, when did the symptoms begin? _____/_____/_____
3. Please explain what you are experiencing_____
_____
_____
4. Is the condition getting worse? □ **YES** □ **NO** □ **CONSTANT** □ **COMES & GOES**
5. List activities that aggravate the condition:_____
_____
_____
6. List activities that are inhibited because of the condition_____
_____
_____
7. Have you had this or a similar condition in the past? □ **YES** □ **NO**
8. Have you been treated by a medical physician for this condition? □ **YES** □ **NO**
9. Are you taking any medication for this condition? □ **YES** □ **NO** If yes, please list:_____
_____
10. Are you suffering from any diseases or other conditions? If so, please describe below_____
_____
_____

Patient/Parent or Legal Guardian Signature:_____

Dr. DiPaolo

5658 N. Main Street, Suite 106 • Sylvania, OH 43560
419.882.7148