Health Horizons
A Family Wellness & Vitality Centre
Chiropractic ▲ Nutrition ▲ Massage
609 Allegheny Avenue | Oakmont, PA 15139 | 412.828.0700 | www.health-horizons.com
Dr. Frank Cicirello | Dr. Katherine Palombini | Dr. Kathy Roth | Dr. Michael Greer

Tell Us About You

Title:_____ First:_____ MI:____ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

City:_____ State:_____ Zip:_____

SS #:_____-_____-_____ Email:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____Ext:_____

Mobile Phone:_____-_____-_____ Preferred contact: ❒ Home ❒ Work ❒ Cell

Referred by:_____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____

# of children:_____ Ages of children:_____

❒ Full-time employment ❒ Part-time employment ❒ Self-employed ❒ Unemployed ❒ Retired

Occupation:_____ Employer:_____

❒ Full-time student ❒ Part-time student School name:_____

Alternate address:_____

City:_____ State:_____ Zip:_____ Parents/Other:_____

Emergency Contact:_____ Phone:_____-_____-_____

Your relationship to emergency contact:_____

Tell Us Why You're Here

What is the primary reason for your visit?_____

_____

Is this due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case ❒ None

When did your pain/symptoms begin (include date if possible)?_____

The overall severity of your complaints/concerns is:

❒ Mild ❒ Mild to moderate ❒ Moderate ❒ Moderately severe ❒ Severe

The overall frequency is: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

On a scale of 1 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ NA

Are your symptoms/pain getting: ❒ Better ❒ Worse ❒ Staying the same

Have you had recent treatment for this condition? ❒ No ❒ Yes—please list dates and doctors:

_____

Have you had the same or similar problems in the past? ❒ No ❒ Yes—When:_____

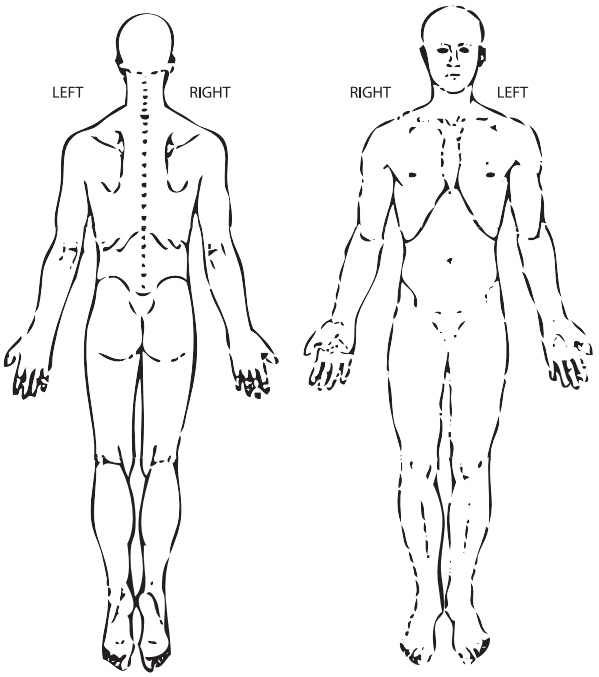
Do you have any additional complaints/concerns/health problems? ❒ No ❒ Yes—please describe:

_____

_____

Use the following key to mark your complaints on the diagram at the right:

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **O**	Stiffness = **X**	Swelling = **S**
Burning = **B**	Tingling = **T**	



If your complaints include pain, how would you describe it? (please check all that apply):

❒ Aching ❒ Burning ❒ Dull ❒ Sharp ❒ Shooting

❒ Stabbing ❒ Throbbing ❒ Other:_____

Since your symptoms began, have you noticed any function changes: ❒ Bowel ❒ Bladder ❒ Sexual ❒ No Changes

Do work activities aggravate your present complaints?

❒ Yes ❒ No

Please mark whether you NOW HAVE (❍) or had IN THE PAST (❒) any of the following conditions/illnesses:

NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST	
❍	❒	Allergies	❍	❒	Difficulty Speaking	❍	❒	Menstrual Problems or Pain
❍	❒	Hay Fever	❍	❒	Sinus Trouble	❍	❒	Prostate Trouble
❍	❒	Fatigue or Weakness	❍	❒	Asthma	❍	❒	Erectile Dysfunction
❍	❒	Night Sweats	❍	❒	Wheezing	❍	❒	Fertility Problems
❍	❒	Unexpected Weight Loss	❍	❒	Chronic Cough	❍	❒	Excessive Thirst
❍	❒	Unexpected Weight Gain	❍	❒	Shortness of Breath	❍	❒	Thyroid Trouble
❍	❒	Sleeping Problems	❍	❒	Chest Pain or Pressure	❍	❒	Anxiety or Nervousness
❍	❒	Skin Problems	❍	❒	Heart Trouble	❍	❒	Mood Swings or Irritability
❍	❒	Loss of Balance	❍	❒	High Blood Pressure	❍	❒	Mental or Emotional Difficulty
❍	❒	Dizziness or Lightheadedness	❍	❒	Low Blood Pressure	❍	❒	Depression
❍	❒	Vertigo	❍	❒	Cold Hands or Feet	❍	❒	Arthritis
❍	❒	Fainting	❍	❒	Abdominal Pain	❍	❒	Bone Fracture
❍	❒	Headaches	❍	❒	Indigestion or Upset Stomach	❍	❒	Dislocated Joints
❍	❒	Seizures	❍	❒	Excess Gas	❍	❒	Autoimmune Disease
❍	❒	Loss of Memory	❍	❒	Heartburn	❍	❒	Cancer
❍	❒	Vision Trouble	❍	❒	Constipation	❍	❒	Diabetes
❍	❒	Hearing Trouble	❍	❒	Diarrhea	❍	❒	Fibromyalgia
❍	❒	Ear Infections	❍	❒	Nausea or Vomiting	❍	❒	Multiple Sclerosis
❍	❒	Ringing or Buzzing in Ears	❍	❒	Bedwetting	❍	❒	Rheumatic Fever
❍	❒	Loss of Smell	❍	❒	Urinary Pain or Frequency	❍	❒	Tuberculosis
❍	❒	Loss of Taste	❍	❒	Kidney or Bladder Trouble	❍	❒	Other:_____
❍	❒	Difficulty Swallowing	❍	❒	Blood in Urine or Stool	❍	❒	**No Conditions/Illnesses**

Your Activities of Daily Living and Work

Please indicate which activities of daily living are compromised by your current state of health:

General:	❒ Walking	❒ Standing	❒ Running	❒ Sports
	❒ Sitting	❒ Lifting children	❒ Bending	❒ Recreational activities
	❒ Climbing stairs	❒ Reading	❒ Lying in bed	❒ Getting into/out of an automobile
	❒ Chewing	❒ Swimming	❒ Using keyboard	❒ Sewing or crafts
	❒ Kneeling	❒ Playing instrument	❒ Exercising	❒ _____
	❒ Sleeping	❒ Using telephone	❒ Sitting in recliner	
Housework:	❒ Doing laundry	❒ Vacuuming	❒ Ironing	❒ Caring for pets
	❒ Making beds	❒ Washing dishes	❒ Carrying groceries	❒ Cooking
Yardwork:	❒ Mowing lawn	❒ Raking leaves	❒ Gardening	❒ Shoveling snow
Personal grooming:	❒ Combing hair	❒ Shaving	❒ In/out of bathtub	❒ Brushing teeth
Travel:	❒ Driving a car	❒ Riding in a car	❒ _____	❒ _____

How often does your job involve lifting? ❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Other job requirements (please check all that apply): ❒ Bending ❒ Carrying ❒ Stooping

❒ Twisting ❒ Turning ❒ Walking ❒ Other:_____

What is your primary work position? ❒ Seated ❒ Standing ❒ Other:_____

Sickness, Injury and Accident History *(please include dates and descriptions)*

Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury):_____

_____

_____

_____

Prior illnesses (other than colds and flu):_____

_____

_____

_____

Surgeries and hospitalizations:_____

_____

_____

_____

Are you currently taking ANY over-the-counter medication: ❒ No ❒ Yes—list name and for what condition.

Are you currently taking ANY prescription medication: ❒ No ❒ Yes—list name and for what condition.

DRUG	CONDITION	DRUG	CONDITION	DRUG	CONDITION

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.

Your Health Habits and Lifestyle

Which is your dominant hand: ❒ Left ❒ Right ❒ Ambidextrous

Which of the following best describes your stress level: ❒ None ❒ Minimal ❒ Moderate ❒ Severe

Do you smoke? ❒ No ❒ Yes—How much:_____

Do you exercise? ❒ No ❒ Yes—How often:_____

How many caffeinated drinks do you consume:_____ per day

How many alcoholic drinks do you consume:_____ per week

Do you have weight issues? ❒ No ❒ Yes

Are you currently taking any vitamins or nutritional supplements: ❒ No ❒ Yes—please indicate which one/s:

_____

Do you have any heavy metal toxicity? ❒ No ❒ Yes—_____ ❒ Unknown

Do you have any "silver" or amalgam dental fillings in your mouth? ❒ No ❒ Yes ❒ Unknown

Do you have any body piercings (aside from ear piercings)? ❒ No ❒ Yes

What type of water is in your home? ❒ City ❒ Well—Date last tested:_____

Do you sleep on your stomach? ❒ No ❒ Yes

Do you carry a wallet in your back pocket? ❒ No ❒ Yes

Do you have any scars from injury or surgery? ❒ No ❒ Yes—_____

How often do you consume processed or prepared foods? ❒ Occasionally ❒ Frequently ❒ Usually

Are the cosmetics and/or personal grooming products you use: ❒ Mainstream ❒ All natural or organic

Are the cleaning products and laundry detergent in your home: ❒ Mainstream ❒ All natural or organic

WOMEN ONLY: To your knowledge are you pregnant? ❒ No ❒ Yes—Due date:_____

Other Health Care Providers

Have you ever been to a doctor of chiropractic before? ❒ No ❒ Yes—How long ago?_____

Name of previous chiropractor:_____

City:_____ State:_____

Do you see a medical doctor or osteopath? ❒ No ❒ Yes—Date of last visit:_____

Name of medical doctor:_____

City:_____ State:_____

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? ❒ No ❒ Yes—_____

_____

_____

_____

_____

Signature:_____ Date:_____ Case:_____