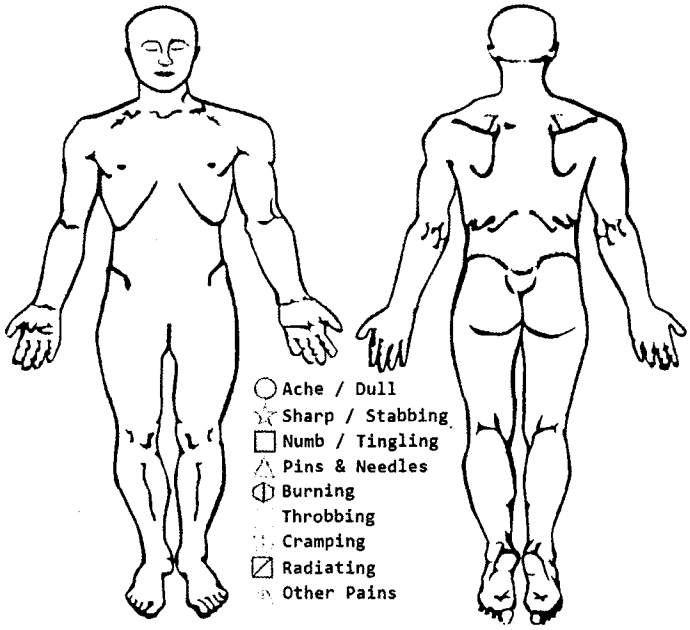
Saponara Brain & Spine Center, PC
1 Mathews Drive Suite 109
Hilton Head Island, SC 29926
843-681-8001

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	○ Male ○ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Symptoms:



Patient Social

Alcohol:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Caffeine:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Diet Food Products:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Drugs:	○ Daily	○ Weekly	○ Occasionaly	○ Never
OTC Stimulants:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Exercise:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Homemade Food:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Processed:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Soft Drinks:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Tobacco:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Water:	○ Daily	○ Weekly	○ Occasionaly	○ Never					

Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

○ Wellness ○ Sports ○ Auto ○ Fall ○ Home Injury ○ Job ○ Chronic Discomfort ○ Other

Briefly Explain: _____

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Results: ○ Good ○ Bad ○ Indifferent

Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency: _____

Missed Work: ○ Yes ○ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ○ Yes ○ No Explain: _____

Reduced Work: ○ Yes ○ No Explain: _____

Does it Worsen: ○ Yes ○ No Explain: _____

Weather Affects it: ○ Yes ○ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ○ Yes ○ No Explain: _____

X-rays Taken: ○ Yes ○ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ○ Yes ○ No Date: _____ Practitioner: _____

For Women Only:

Are you pregnant? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Do you experience painful periods? ○ Yes ○ No Do you have irregular cycles? ○ Yes ○ No

Do you perform a regular self breast examination? ○ Yes ○ No Do you have breast implants? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Date of last PAP/pelvic exam? _____ Date of last mammogram? _____ Date of Last Menstrual Period? _____

Complaint Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

Date of scheduled appointment _____ When did this condition begin? _____

How long have you had this condition? _____ What caused this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #1 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #2 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #2 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Review of Systems:

Musculoskeletal - Other than the musculoskeletal complaints you mentioned already, do you have or have you ever had:

- ☐ No additional musculoskeletal complaints
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Joint or muscle pains/stiffness
- ☐ Cramping
- ☐ Swelling, redness deformity of joint(s)
- ☐ Fractures
- ☐ Implants, plates, pins or screws
- ☐ Neck pain
- ☐ Back problems
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot/ankle pain
- ☐ Shoulder problems
- ☐ Elbow/wrist pain
- ☐ Poor posture
- ☐ Gout

Neurological - Other than the neurological complaints you mentioned already, do you have or have you ever had:

- ☐ No additional neurological complaints
- ☐ Anxiety and/or panic
- ☐ Depression
- ☐ Memory issues
- ☐ Sleeping issues
- ☐ Headache
- ☐ Dizziness
- ☐ Weak muscles
- ☐ Pins and needles
- ☐ Numbness
- ☐ Loss of smell or taste
- ☐ Temporary loss of vision, smell or hearing
- ☐ Difficulty concentrating
- ☐ Stroke
- ☐ Epilepsy or seizures

Head, Eyes, Ears, Nose and Throat - Do you have or have you ever had:

- ☐ No complaints
- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contact lenses
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Nose congestion or sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ problems
- ☐ Sore throat
- ☐ Postnasal drip
- ☐ Swollen lymph nodes
- ☐ OTHER

Cardiovascular - Do you have or have you ever had:

- ☐ No cardiovascular complaints
- ☐ Chest pain or tightness
- ☐ Palpitations
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ OTHER

Respiratory - Do you have or have you ever had:

- ☐ No respiratory complaints
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Snoring issues
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Blood in sputum
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Hay fever
- ☐ OTHER

Gastrointestinal - Do you have or have you ever had:

- ☐ No gastrointestinal complaints
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Bloating
- ☐ Heartburn
- ☐ Ulcer
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Colon cancer or colon polyps
- ☐ Hemorrhoids
- ☐ Food sensitivities
- ☐ Constipation
- ☐ Severe diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Collitis
- ☐ OTHER

Genitourinary - Do you have or have you ever had:

- ☐ No genitourinary complaints
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Sexual dysfunction
- ☐ Incontinence
- ☐ OTHER

Review of Systems (2):

Endocrine - Do you have or have you ever had:

- ☐ No endocrine complaints
- ☐ Feeling hot or cold all the time
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Increase urination
- ☐ Excessive thirst
- ☐ Hyperthyroidism
- ☐ Hyperparathyroidism
- ☐ Testosterone deficiency
- ☐ Cushing's syndrome
- ☐ Steroid treatments
- ☐ OTHER

Dermatological and Bleeding - Do you have or have you ever had:

- ☐ No skin or bleeding complaints
- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Change in hair or nails
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Blood in stool
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ OTHER

For Women Only:

Are you pregnant? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Do you experience painful periods? ○ Yes ○ No

Do you have irregular cycles? ○ Yes ○ No

Do you perform a regular self breast examination? ○ Yes ○ No

Do you have breast implants? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Date of last PAP/pelvic exam? _____

Date of last mammogram? _____

Date of Last Menstrual Period? _____

Intensive Pediatric Evaluation:

Physical Stressors:

Were there any significant falls or traumas to the mother during the pregnancy? ○ Yes ○ No ○ Unsure

List any evidence of birth trauma:

☐ Bruising ☐ Cord around neck ☐ Fast or slow birth ☐ None ☐ Odd-shaped head

☐ Respiratory depression ☐ Stuck in birth canal ☐ Unknown/unsure ☐ OTHER

Does the child have any history of serious falls or injuries, including fractures, concussions, hospitalizations, etc.? ○ Yes ○ No ○ Unsure

Does the child wear a backpack? _____

Does child participate in sports or exercise activities? _____

Does child engage in any hobbies or activities which require prolonged, awkward or repetitive postures (violin, gymnastics, ballet, etc.)?

○ Yes ○ No ○ Unsure ○ OTHER

Chemical Stressors:

As an infant, was the child breastfed? ○ Yes, until... ____ months ○ Yes, still breast feeding ○ No ○ Unsure

Was formula introduced? ○ Yes, at... ____ months ○ No ○ Unsure ○ OTHER

Was cow's milk introduced? ○ Yes, at... ____ months ○ No ○ Unsure ○ OTHER

Have solid foods been introduced? ○ Yes, at... ____ months ○ No ○ Unsure ○ OTHER

Does the child have any food, liquid or juice intolerances or allergies? ○ Yes ○ No ○ Unsure ○ OTHER

During the pregnancy, did the mother smoke? ○ Yes ○ No ○ Unsure

During the pregnancy, did the mother drink alcohol? ○ Yes ○ No ○ Unsure

During the pregnancy, did the mother use recreational drugs? ○ Yes ○ No ○ Unsure

Did the mother suffer any illnesses during the pregnancy? ○ Yes ○ No ○ Unsure ○ OTHER

Were any nutritional supplements prescribed or taken during the pregnancy? ○ Yes ○ No ○ Unsure

Were ultrasound(s) performed during the pregnancy? ○ Yes ○ No ○ Unsure

Were any invasive procedures performed during the pregnancy (Amniocentesis, Cerclage, etc.)? ○ Yes ○ No ○ Unsure

Are there any pets in the child's home? ○ Yes ○ No ○ Unsure

Are there any smokers in the child's home or environment? ○ Yes ○ No ○ Unsure

Has the child had any adverse reactions to vaccinations or medicines? ○ Yes ○ No ○ Unsure

Is there any history of antibiotics given to the child? ○ Yes ○ No ○ Unsure

Psychosocial Stressors:

Have there been any difficulties with child-parent bonding? ○ Yes ○ No ○ Unsure

Does the child have any behavioral problems? ○ Yes ○ No ○ Unsure

Have any of the following behaviors occurred? Check all that apply.

☐ Attention issues ☐ Bedwetting ☐ Difficulty sleeping ☐ Failure to maintain eye contact

☐ Hearing issues ☐ Nervous tics ☐ Night terrors ☐ Sleepwalking

☐ Stutter or stammer ☐ Unsure ☐ OTHER

On average, how many hours per week of television does the child watch? _____

Do you feel the child's social and emotional development is normal for their age? ○ Yes ○ No ○ Unsure

Was there any delay in terms of the child's achievement of developmental goals? Choose all that apply.

☐ None, all developmental goals were met on schedule

☐ Delayed response to sound ☐ Delayed ability to follow an object ☐ Delayed ability to hold head up ☐ Delayed ability to vocalize

☐ Delayed ability to sit alone ☐ Delayed normal appearance of teeth ☐ Delayed ability to crawl ☐ Delayed ability to walk

☐ Unsure ☐ OTHER

Health Checklist:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] CHF
- [ ] Cold Extremities
- [ ] Constipation
- [ ] COPD/emphysema
- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Diagnosed emotional/mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder disease/stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver disease/cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Retinal Disease
- [ ] Sciatica
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoked
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

_____

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

○ Type I ○ Type II ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ○ Yes ○ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

Medications: _____

Supplements: _____

Personal Incident History:

Broken Bones: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Sprains/Strains: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Hospitalized: ○ Yes ○ No Explain: _____

Surgery: ○ Yes ○ No Explain: _____

Auto Accident: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Struck Unconscious: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Eating Disorder: ○ Yes ○ No Explain: _____

Stroke: ○ Yes ○ No Explain: _____

Family Health History:

Family Health History

EHR Information:

Preferred Language _____ Ethnicity _____ Race _____

Smoking Status _____ Smoking Start Date _____ Tried to quit? ○ Yes ○ No

Type of Tobacco ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigar ☐ Pipe ☐ Other

How much tobacco do you use? _____ How long have you used tobacco? _____

Current Medications And Dosage

Medication Allergies

☐ I choose to decline receipt of my clinical summary after every visit

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster. I understand and agree that all services rendered to me will be charged to me at the time of service. Saponara Brain & Spine Center, PC does not accept insurance. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____