DR. DAYNA D'ACIERNO

856 GOLD HILL RD, STE 103 FORT MILL, SC 29708 803-802-6637

CONFIDENTIAL PATIENT INTAKE QUESTIONNAIRE

NAME_____ AGE_____ DATE OF BIRTH_____

ADDRESS_____

CELL PHONE_____ EMAIL_____

HEIGHT_____ WEIGHT_____ OCCUPATION_____

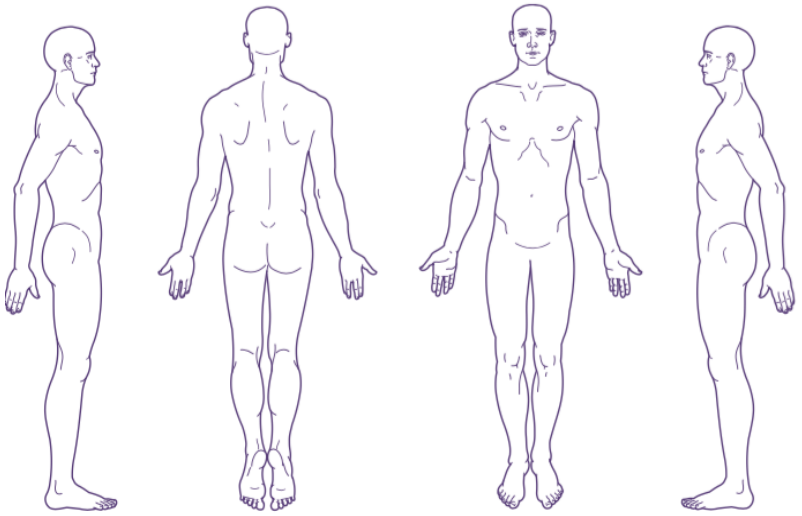
WHO MAY WE THANK FOR REFERRING YOU?_____

CURRENT HEALTH CONCERNS:

1) CIRCLE AREAS OF PAIN OR CONCERN

2) RATE PAIN SEVERITY 1=VERY MILD, UP TO 10=UNBEARABLE

3) RATE FREQUENCY BY PLACING A LETTER NEXT TO EACH AREA:
   O=OCCASIONAL, UP TO 25% OF DAY
   F=FREQUENT, UP TO 50% OF DAY
   V=VERY FREQUENT, UP TO 75% OF DAY
   C=CONSTANT, UP TO 100% OF DAY



LIST ANY ACTIVITIES THAT AGGRAVATE YOUR SYMPTOMS:

_____

_____

WHEN DID THIS BEGIN_____ HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST? Y_____ N_____

HOW IS IT PROGRESSING? GETTING WORSE_____ GETTING BETTER_____ STAYING THE SAME_____ COMES AND GOES_____

HAVE YOU TRIED ANY TREATMENT FOR THIS CONDITION? Y____ N____ IF YES, WHAT_____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? Y____ N____ IF YES, DOCTOR'S NAME_____

SURGERIES, AUTO ACCIDENTS, OTHER INJURIES AND APPROXIMATE DATES:_____

_____

PLEASE LIST ANY ACTIVITIES THAT YOU HAVE DIFFICULTY WITH DUE TO PHYSICAL LIMITATIONS OR PAIN_____

_____

ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW_____

_____

SIGNATURE_____ Date_____