OTTAWA
CHIROPRACTIC

Dr. Daniel P. Farrell & Dr. Kathryn M. Flaherty
1001 Clinton St. ~ Ottawa, IL 61350

PERSONAL:

Name:	Address:
Prefer to be Called:	City/State/Zip:
□ Male □ Female	Phone: Home:
Date of Birth: Age:	Mobile:
SS#:	Email:
Marital Status:	How do you prefer to be reminded for future appointments? Home Mobile Text Email None
Spouse's Name:	Mobile Phone Carrier:
Spouse's Date of Birth:	Children:
Spouse's SS#:	**Referred by:**

Employer: Patient	**Employer: Spouse**
Name:	Name:
Address:	Address:
Phone:	Phone:
Medical Doctor:	Emergency Contact:
Last Visit:	Ph #:

I am seeking care at this office for: (check one of the following)

____ Temporary relief of symptoms
____ Relief of symptoms and stabilization of the problem (Initial Intensive Care)
____ Relief, stabilization and correction of the problem (Spinal Reconstructive Care)
____ No symptoms, interested in maintaining optimum health (Wellness Care)

Reason for seeking chiropractic care: complaints / concerns / issues....

_____

_____

I UNDERSTAND THE INFORMATION ABOVE IS CORRECT, AND ALL TREATMENTS, X-RAYS AND LABORATORY EXAMINATIONS ARE TO BE PAID FOR AS THEY ARE RECEIVED OR DEFINITE FINANCIAL ARRANGEMENTS ARE TO BE MADE IN ADVANCE.

PATIENT (please print) DATE:

PATIENT SIGNATURE Relationship of Authority if not signed by the patient

OTTAWA
CHIROPRACTIC

Dr. Daniel P. Farrell & Dr. Kathryn M. Flaherty
1001 Clinton St. ~ Ottawa, IL 61350

Name: _____ Date: _____

List surgical operations and year: _____

_____

List the pills you now take: prescription / over the counter / vitamins: _____

_____

How do you sleep: □ Side □ Back □ Stomach

Age of mattress: _____ □ Comfortable □ Uncomfortable Number of pillows used: _____

Are you wearing: □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

Have you been in an automobile accident: □Past year □ Past five years □ Over five years □ Never

Describe: _____

_____

HAVE YOU EVER: (describe briefly)

Had any mental or emotional disorders?	□ No □ Yes When: _____
Had an allergy to any food or drug?	□ No □ Yes _____
Been knocked unconscious?	□ No □ Yes _____
Used a cane, crutch, or other support?	□ No □ Yes _____
Been treated for a spine or nerve disorder?	□ No □ Yes _____
Had a fractured bone?	□ No □ Yes _____
Been hospitalized for anything other than surgery?	□ No □ Yes _____

Regarding today's visit, how would rate your pain/discomfort at the moment, as well as when your pain is at its worst?

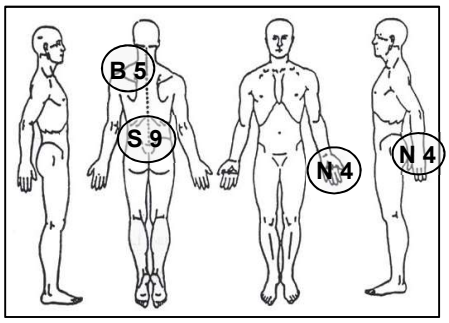
EXAMPLE: 0 (no pain) 1 2 (3) 4 5 6 (7) 8 9 10 (most severe)

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

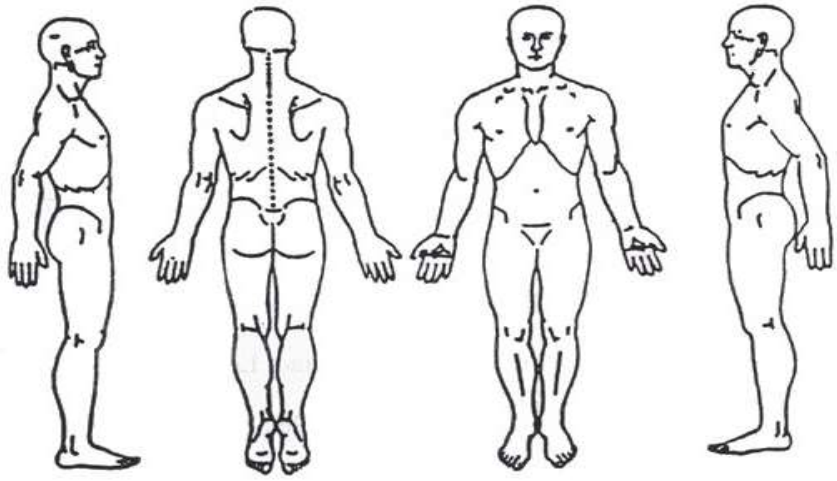
Please complete the diagram, indicating any area of complaint, including the pain description and discomfort/pain rating.

Pain/discomfort Scale of 0-10: 0 = No Pain; 10 = Most Severe Pain Imaginable)

Description: Achy (**A**) Burning (**B**) Dull (**D**) Pins & Needles (**P**) Numbness (**N**) Sharp (**S**) Throbbing (**T**)



EXAMPLE



OTTAWA CHIROPRACTIC

Dr. Daniel P. Farrell & Dr. Kathryn M. Flaherty
1001 Clinton St. ~ Ottawa, IL 61350

Patient Name:_____ Date:_____

Please check the appropriate box for any of the following symptoms which you now have, or have had previously.

O = Occasional
F = Frequent
C = Constant

GENERAL

O	F	C	
□	□	□	Allergy
□	□	□	Chills
□	□	□	Convulsions
□	□	□	Dizziness
□	□	□	Fainting
□	□	□	Fatigue
□	□	□	Fever
□	□	□	Headache
□	□	□	Loss of sleep
□	□	□	Loss of weight
□	□	□	Nervousness/depression
□	□	□	Neuralgia
□	□	□	Numbness
□	□	□	Sweats
□	□	□	Tremors

MUSCLE & JOINT

□	□	□	Arthritis
□	□	□	Bursitis
□	□	□	Foot trouble
□	□	□	Hernia
□	□	□	Low back pain
□	□	□	Neck pain or stiffness
□	□	□	Pain between shoulders

Pain or numbness in:

□	□	□	Shoulders
□	□	□	Arms
□	□	□	Elbows
□	□	□	Hands
□	□	□	Hips
□	□	□	Legs
□	□	□	Knees
□	□	□	Feet
□	□	□	Painful tail bone
□	□	□	Poor posture
□	□	□	Spinal curvature

GASTROINTESTINAL

O	F	C	
□	□	□	Belching or gas
□	□	□	Bloating
□	□	□	Colitis
□	□	□	Colon trouble
□	□	□	Constipation
□	□	□	Diarrhea
□	□	□	Difficult digestion
□	□	□	Excessive hunger
□	□	□	Gall bladder trouble
□	□	□	Hemorrhoids
□	□	□	Jaundice
□	□	□	Liver trouble
□	□	□	Nausea
□	□	□	Pain over stomach
□	□	□	Poor appetite
□	□	□	Vomiting
□	□	□	Vomiting of blood

EYES, EARS, NOSE & THROAT

□	□	□	Asthma
□	□	□	Colds
□	□	□	Crossed eyes
□	□	□	Deafness
□	□	□	Dental decay
□	□	□	Earache
□	□	□	Ear discharge
□	□	□	Ear noises
□	□	□	Enlarged glands
□	□	□	Enlarged thyroid
□	□	□	Eye pain
□	□	□	Failing vision
□	□	□	Farsightedness
□	□	□	Nearsightedness
□	□	□	Gum trouble
□	□	□	Hay fever
□	□	□	Hoarseness
□	□	□	Nasal obstruction
□	□	□	Nosebleeds
□	□	□	Sinus infection
□	□	□	Sore throat
□	□	□	Tonsillitis

CARDIOVASCULAR

O	F	C	
□	□	□	Hardening of arteries
□	□	□	High blood pressure
□	□	□	Low blood pressure
□	□	□	Pain over heart
□	□	□	Poor circulation
□	□	□	Rapid heart beat
□	□	□	Slow heart beat
□	□	□	Swelling of ankles

RESPIRATORY

□	□	□	Chest pain
□	□	□	Chronic cough
□	□	□	Difficult breathing
□	□	□	Spitting up blood
□	□	□	Spitting up phlegm
□	□	□	Wheezing

SKIN

□	□	□	Boils
□	□	□	Bruise easily
□	□	□	Dryness
□	□	□	Hives or allergy
□	□	□	Itching
□	□	□	Skin eruptions (rash)
□	□	□	Varicose veins

GENITOURINARY

□	□	□	Bed wetting
□	□	□	Blood in urine
□	□	□	Frequent urination
□	□	□	Inability to control kidneys
□	□	□	Kidney infection or stones
□	□	□	Painful urination
□	□	□	Prostate trouble
□	□	□	Pus in urine

FOR WOMEN ONLY

□	□	□	Congested breasts
□	□	□	Cramps or backache
□	□	□	Excessive menstrual flow
□	□	□	Hot flashes
□	□	□	Irregular cycle
□	□	□	Menopausal symptoms
□	□	□	Painful menstruation
□	□	□	Vaginal discharge

□ **Yes** □ **No** **Are you pregnant?**
□ Yes □ No Miscarriage?

CHECK THE FOLLOWING CONDITIONS YOUR HAVE HAD:

□ Alcoholism	□ Chicken Pox	□ Epilepsy	□ Measles	□ Polio
□ Anemia	□ Cold Sores	□ Fever Blisters	□ Multiple Sclerosis	□ Stroke
□ Appendicitis	□ Diabetes	□ Gout	□ Mumps	□ Ulcers
□ Arthritis	□ Eczema	□ Heart Disease	□ Pleurisy	□ Whooping Cough
□ Cancer	□ Emphysema	□ Influenza	□ Pneumonia	Other _____

OTTAWA
CHIROPRACTIC
Dr. Daniel P. Farrell & Dr. Kathryn M. Flaherty
1001 Clinton St. ~ Ottawa, IL 61350

Family Health History

Patient Name:_____ Date:_____

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply.

CONDITION	Father Age ( )	Mother Age ( )	Spouse Age ( )	Maternal Grandparents Age ( ) Age ( )	Paternal Grandparents Age ( ) Age ( )	Children Age ( ) Age ( ) Age ( ) Age ( )
Arthritis						
Bursitis/disc/ back trouble						
Neuritis/neuralgia						
Scoliosis						
Cancer						
Digestive problems ie: Constipation/Irritable bowel syndrome/ Crohn's disease)						
Diabetes						
Epilepsy						
Headaches/migraines						
Heart Trouble						
High blood pressure						
Insomnia						
Kidney trouble						
Liver trouble						
Lung problems ie: asthma /COPD/emphysema						
Mental health issues						
Sinus trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____