BATTAGLINO FAMILY CHIROPRACTIC

PATIENT INFORMATION SHEET

Legal First Name:_____ Middle Initial____Last Name_____

Preferred to be call:_____ Sex ☐ Male ☐ Female

Address:_____City:_____State:_____Zip:_____

Date of Birth:____/____/_____Age: _____Marital Status: Single☐ Married ☐ Other ☐ SS#_____-_____-_____

Email Address:_____Cell #:(___)_____-_____Home#: (____)_____-_____

Occupation:_____Employer:_____

Partner's Name:_____# of children:_____

Name of Emergency Contact_____ Relationship:_____Phone #: (___)_____-_____

Who may we thank for referring you to our office?_____

Have you ever received chiropractic care before? Yes ☐ No☐ _____

Is this treatment related to an injury? Yes ☐ No ☐ If yes, select type: Automobile ☐ Work ☐ Other ☐
Date of Accident: ____/____/____ Address:_____ City_____

	Excellent	Good	Poor
How would you rate your quality of sleep?	☐	☐	☐
How would you rate your physical health?	☐	☐	☐
How would you rate your emotional health?	☐	☐	☐
How would you rate your overall level of happiness?	☐	☐	☐
How would you rate your overall level of stress?	☐	☐	☐
How would you rate your overall energy level?	☐	☐	☐

Please list any past major traumas and/or accidents you have experienced?

_____

_____

_____

_____

Please list all symptoms you are currently experiencing:

SYMPTOM	**SEVERITY** (1-10) (10 = most severe)	**FREQUENCY** Constant, Intermittent (daily), Occasional, or Seldom
1.		
2.		
3.		
4.		
5.		
6.		

620 Petaluma Boulevard North, Ste B. The Hatchery Building
Petaluma, CA 94952 • (707) 559-4070 • www.battaglinochiropractic.com

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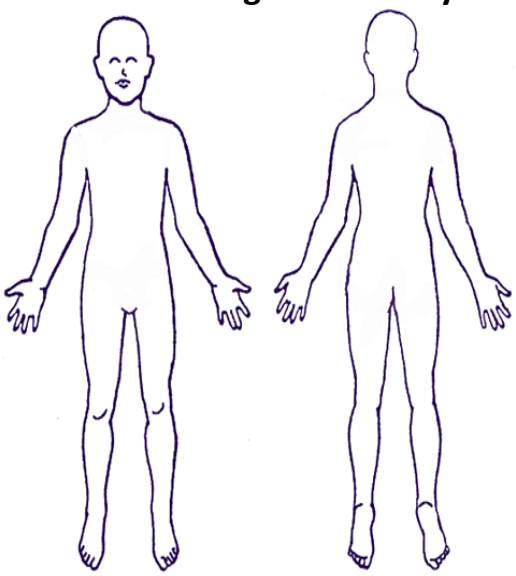
Please mark an "X" on the diagram where your problems are:



Check any of the following that you have had in the last six months:

□ Headaches	□ Prostate/Sexual Dysfunction	□ Diarrhea
□ Allergies	□ Menstrual Cycle Dysfunction	□ Diabetes
□ Vision Problems	□ Discolored Urine	□ Cancer
□ Poor/Excessive Appetite	□ Nausea/Vomiting	□ Numbness
□ Ankle Swelling	□ Abdominal Cramps	□ Excessive Thirst
□ Heart Problems	□ Constipation	□ Dizziness
□ Lung Problems/ Congestion	□ Painful Urination	□ Ear Aches
□ Blood Pressure Problems		

Are you pregnant? Yes □ No □ Not sure □

Please list other Chiropractic or Medical Doctors you have consulted for these conditions:

_____

_____

I authorize Battaglino Family Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient Signature:_____Date: ___/___/___

Guardian Authorizing Care Signature:_____ Printed Name:_____ Date:___/___/__

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