Dr. John Bellomo
Director

6442 Edgewater Drive
Orlando, Florida 32810
(407) 295.1077

PRACTICE MEMBER INFORMATION (*PLEASE PRINT CLEARLY)* Date: ______________________

First Name, M.I., and Last Name ____

Street Address (include APT #): ____

City, State, and Zip: ____

Email Address: ____________________________ Cell Phone Number: _________________________

Home Phone Number: _______________________ Date of Birth: ___________________ Age: _______

Sex: M F Marital Status: M S W D Employer Name: ___________________________

Occupation: ______________________________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? Check one and complete

- _____Family Name: _______________________ Number: _____________________
- _____Friend Name: _______________________ Number: _____________________
- _____Online/Website:
- _____Spinal Screening: Event Name: _____________________________________
- _____Other: ____

1. What is motivating your visit with us today? ____________________________________
2. Presently on a scale of 0 to 10 (0=no affect, 10=highest affect), how much of what you are experiencing is affecting your life? **(circle one)**

   1 2 3 4 5 6 7 8 9 10

3. Are you sensing "now" is the time to start making healthier lifestyle changes**?** **(circle one)** Yes No
4. Previous stressors: **Circle the ones you have experienced in the last year.**

   Emotional Mental Physical Chemical Environmental

Previous Injuries: ____

Previous Surgery: ____

NAME: ____

Are you bothered by:

Pain in: (Check all that apply)

( ) Arms ( ) Abdomen ( ) Chest ( ) Ears ( ) Feet

( ) Fingers ( ) Hands ( ) Hips ( ) Leg ( ) Low Back

( ) Mid back ( ) Neck ( ) Ribs ( ) Shoulder (circle) Right Left

( ) Toes

Do you have any pain, tingling, or numbness radiating down any of your extremities? Yes No

Which extremities do you experience radiating pain, tingling, or numbness? ______________________

Does your body ever express any of the following manifestations: Check all that apply

( ) ADD Attention Deficit Disorder		( ) Allergies	( ) Asthma
( ) Arthritis	( ) Bladder Trouble	( ) Blindness	( ) Birth Trauma
( ) Cancer	( ) Constipation	( ) Cramps	( ) Deafness
( ) Depression	( ) Diabetes	( ) Ear Infection	( ) Fatigue
( ) Fibromyalgia	( ) Gastrointestinal Trouble		( ) Heart Trouble
( ) Headache	( ) Indigestion		( ) Kidney Trouble
( ) Lung Trouble	( ) Migraines		( ) Nausea
( ) Nervousness	( ) Poor Circulation		( ) Paralysis
( ) PMS	( ) Stress		( ) Stiffness
( ) Sinusitis	( ) Other: ______________________________		

Are you taking medication: Yes No Please list what type: ______________________________

____

Does your present condition interfere with normal living or work activities? Yes No

Have you ever had chiropractic before? Yes No How long ago? _______ With whom: _______________

Do you desire (circle one): Temporary Relief Care Lasting Corrective Care

Who will be discussing financial arrangements with? ____Self ____Spouse ____Both ____Parent

For female members: Are you pregnant? ________ Date of last menstruation: ______________________

MEMBER SIGNATURE: ______________________________ Date: ____________________