



Dr. John Bellomo
Director

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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: _____

Who will you be discussing financial arrangements with? ___Self ___Spouse ___Both ___Parent

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)

- Fingers Hands Hips Leg Low Back
 Mid back Neck Ribs Shoulder (circle) Right Left
 Toes Other: _____

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

Which extremities (*specify side*)? _____ Circle all that apply: Tingling Pain 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

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

MEMBER SIGNATURE: _____

Date: _____