FOCUSED HEALTH Chiropractic

Dr. Susan Sirianni
Dr. Tristan Burton
Dr. Kristen Lawrenz
Dr. Karen Santini

2349 Monroe Avenue
Rochester, NY 14618
phone: 585.442.6030

Patient Name:____Today's Date:_______________

Gender: ________ Date of Birth:_______________ Age:_______ Nickname:_____________________________

Address:____

City:____ State:________________ Zip:_______________________

Phone: (H):__________________________ (W):____________________________ (C):_______________________

Email Address:____ (For appointment reminders)

Emergency Contact:_______________________________ Phone:_______________ Relationship:_______________

Marital Status: _______ Spouse/Partner____ # Children_______

Primary Care Physician:____

Whom may we thank for referring you to our practice?____

HEALTH HISTORY

Main condition/symptom today:____

How long have you had these conditions/symptoms?____

Height: ___feet ___inches Weight:_______ Last known blood pressure: _____/____ Hypertension: Yes___ No___

Surgeries:____ Approx date:________________

Hospitalizations: ____ Approx date:_________________

Major Illnesses:____ Approx date:_________________

Diabetes: Yes*_____ No_____ *If yes: Type I_____ Type II_______

Cancer: Yes_____ No_____ Type/Dates:____

Please circle any conditions or symptoms which are **currently or have previously** caused any problems.

General Symptoms
Headache
Recent fever
Dizziness
Loss of sleep
Nervousness/anxiety
Weight loss
Rashes/itching
Bruise easily
Asthma
Bowel/urinary problems
Prostate
Chest Pain
Autoimmune disease
Diabetes

Gynecological
Painful menstruation
Menopausal symptoms

Have you ever had any Fractures? Yes/No

Muscles & Joints
Neck pain
Back pain
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Foot pain
Arthritis
Numbness/tingling
Swollen joints

Are you currently on Birth control? Yes / No
Births ____________
C-Sections_________

Have you ever been in a car accident? Yes/No`

Cardio Vascular
High blood pressure
Stroke
Poor circulation/Raynaud's
High cholesterol

Gastrointestinal
Indigestion/reflux
Nausea
Constipation
Diarrhea
Gall bladder trouble

EENT
Blurred vision
Frequent colds
Sinus Infection
Difficulty swallowing

Are you currently taking any medications? (Include regularly used over-the-counter medications: Yes___ No_____

Medication Name **For what condition?**

_________________________________ ____

_________________________________ ____

_________________________________ ____

_________________________________ ____

Do you have any medication allergies? No_____ Yes*_____ If yes, please explain below

Medication Name	**Reaction**	**Onset Date**	**Additional Comments**
___________________	_____________	_____________	___________________________________
___________________	_____________	_____________	___________________________________
___________________	_____________	_____________	___________________________________

Family Medical History

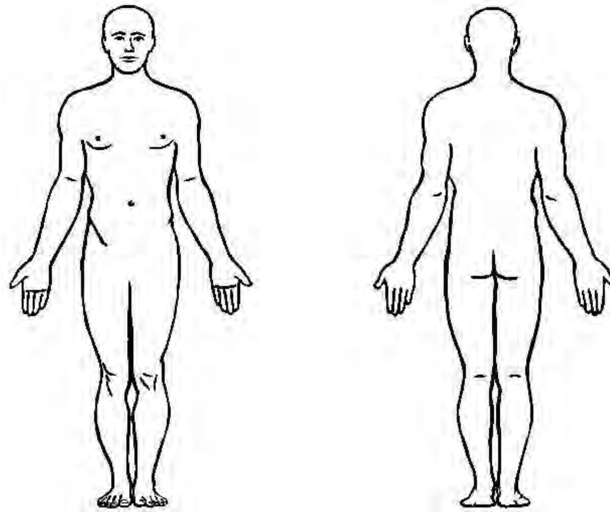
Place a check for family history

	Grand parents	Parents	Siblings
Cardiovascular			
Cancer			
Autoimmune disease			
Diabetes			
Other			

Current Complaints

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:

SHARP/STABBING	++++
DULL/ACHEY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////



Pain scale: please circle your pain level

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

Do you have pain every day? Yes_____No_____ Does pain wake you at night? Yes____ No_____

What increases your pain?____

What decreases your pain?____

Are your symptoms Worsening_____ Unchanged_____ Improved______

Do you perform neck/back exercises Yes_____ No_____

Have you seen other doctors for this condition? If so, who:____

Date of last physical exam:________________________ Date of last spinal X-Ray /CT/MRI:____________________________

Social History check all that apply

Living with: spouse_____ alone_____ other_____

Smoking: never_____ former_____ every day_____ occasionally_____ date started smoking_____________

Caffeine: never_____ less than 3/day_____ 3-6 per day_____ more than 3-6 per day_____

Alcohol: never_____ casual_____ moderate_____ excessive_____ wine_____ beer_____

Recreational drug use: none_____ recreational_____ addiction_____

Exercise: never_____ daily_____ weekly_____ walk_____ run_____ swim_____

lift weights w/resistance_____ yoga/pilates_____ other_____________________________

Occupation:____ or unemployed_______ student_____ retired_____

Employer:____

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Pediatric Patient Information

Child's Name:____ Date:________________________

Gender:________ Date of Birth:___________________ Age:_________ School Grade:_______________

Home Phone:_________________________________

Parent E-Mail Address:____

Address:____________________________________City:____________________ State:_____Zip________

Mother's Name:____ Cell/Work Phone:____________________

Father's Name:____ Cell/Work Phone:____________________

Purpose of this appointment:____

Pediatrician:____ Phone:____________________________

Mother's Pregnancy History (if child is adopted, answer to the best of your ability)
Select any of the following you experienced during your pregnancy:

____Severe viral infection during first trimester
____Breech position during pregnancy
____Accident or infections
____Smoking
____Severe stress
____Pre-eclampsia
____Alcohol consumption and/or drug use
____Radiation exposure
____Hypertension (high blood pressure)
____Toxoplasmosis
____Uncontrolled diabetes
____Toxemia

Mother's Labor & Delivery History
Select any of the following you and/or the child experienced during labor/delivery:

____Hospital Birth
____Birthing Home
____Long and/or difficult labor
____Placenta Previa
____ Forceps or suction cups used
____Fetal distress
____Elective C-Section
____ Child was a "blue baby"
____Home Birth
____Induced Labor
____ Rapid delivery
____Breech birth
____ Cord around the neck
____Emergency C-Section
____Premature delivery (2+ weeks)

Comments:____

____

Newborn History
Select any of the following that your child experienced as a newborn:

____Required resuscitation/oxygen
____Prolonged jaundice
____Poor sleeper
____ Immunizations in hospital
If yes, specify vaccine:______________________
____
Weight at birth:___________________________

____Distorted skull
____Difficulty latching/sucking
____ Formula fed
____Breast fed
____Bottle fed
____Colic
Length at birth:__________________________

Health History
Select any of the following that your child has experienced or been diagnosed with:

____Illnesses accompanied by high fever
____Frequent headaches
____Seizures/convulsions
____Chronic ear infections/earaches
____Head injury
____Serious fall(s) or repetitive falls
____Epilepsy
____Meningitis
____Allergies to foods
____Environmental allergies
____Chemical sensitivities
____Surgery
____Neck or back problems
____Adverse reaction to any vaccinations (even mild)

____Dizziness
____Diabetes
____Hypoglycemia (low blood sugar)
____Trouble with bladder control (enuresis)
____Fainting
____ High blood pressure
____ Heart disease
____Asthma
____Sinus problems
____Constipation
____Diarrhea
____Digestive disorders
____Rheumatic fever
____Joint or muscle problems

If yes, please explain____

Developmental History
Select all that apply or did apply:

____Difficulty crawling (on all fours)
____Difficulty learning to ride a bike
____Difficulty learning to read
____Difficulty using utensils
____Difficulty tying shoes
____Poor hand-eye coordination

____Did not crawl on all fours
____Appears clumsy
____Difficulty with writing
____Difficulty buttoning clothes
____Difficult or awkward when walking/running
____Difficulty sitting still or paying attention

____Age that your child started to walk unassisted:________

Comments:____

____

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following? If yes, by whom?

____Hearing loss or impairment
____Neurological disorders
____Obsessive Compulsive Disorder (OCD)
____ADD/ADHD
____Dyslexia
____Visual Impairment
____Anxiety/Depression requiring treatment
____Autism/Autism Spectrum Disorder
____Tourette's Syndrome
____Other

Current/Past Medications and Treatments

List any medications your child is taking
List names, dosage and frequency)
____

____

List any supplements your child takes:

____

____

List any special services that your child is currently receiving at school or privately
____

____

List any special dietary needs that your child has:
____

____

List any treatment that your child is currently undergoing with any health professional
____

____

List any previous alternative treatment, medications or other medical treatment that your child has undergone:_________________________________

____

Main Condition/Symtpoms:____

Other conditions/symptoms:____

How long has your child had these conditions/symptoms?____

Height: ____feet ____inches Weight:_______

Last known blood pressure______ / _____ Hypertension: ____Yes ____No

Surgeries____ Approx Dates:______________________

Hospitalizations____ Approx Dates:______________________

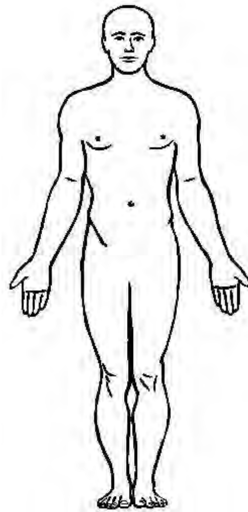
Major Illnesses:____ Approx Dates:______________________

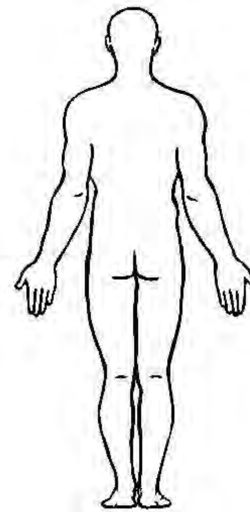
Diabetes: ____Yes* ____No *IF yes: ____Type I ____Type II

CURRENT COMPLAINTS

On the diagram, please indicate the location of pain and symbol that best describes what your child is experiencing:

SHARP/STABBING	++++
DULL/ACHEY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////





Does your child have pain every day? ____Yes ____No

Does your child's pain wake you at night? ____Yes ____No

Are your child's symptoms: ____Worsening ____Unchanged ____Improving

What increases your child's pain?____

What decreases your child's pain?____

Has your child seen other doctors for this condition? If so, who?_________________________________

Date of last physical exam:_____________________________

Date of last spinal X-rays/MRI's: ________________________

Has your child had previous chiropractic care? ____Yes ____No