

Needham Family Chiropractic
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Confidential Health Information

PERSONAL INFORMATION

DATE: _____ REFERRED BY: _____
Name: _____ SS# _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: _____ Marital Status: S M D W L/W
Occupation: _____ Employer: _____
Business Address: _____ Business Phone: _____
Name of Spouse: _____ Occupation: _____
Ages of Children: _____
Nearest Relative (not living with you): _____

PRESENT HEALTH STATUS

Reason for consulting this office (please be specific): _____

If a major complaint or problem is present, please answer these questions:

When did it start? _____

Describe what you are feeling? _____

Have you ever had this condition before? _____

Is this condition getting: ___ progressively worse, ___ constant, ___ comes & goes, ___ better

Is this condition interfering with your: ___ work, ___ sleep, ___ daily routine, ___ other.

If "other" please explain: _____

What do you believe is wrong with you? _____

Have you consulted other doctors or health professionals for this problem? _____

If so, whom? _____

HEALTH HISTORY

What significant health problems have you had in the past? _____

What accidents, falls or injuries (even minor ones) have you had? Note: This includes childhood falls, contact sports etc. _____

Have you ever broken or fractured any bones? ___ Yes ___ No

Describe how it occurred. _____

What surgeries or operations have you had? (indicate dates) _____

MEDICATIONS

Drugs or medications you currently take: Tranquilizers Pain Killers Muscle Relaxants
 Pep Pills Birth Control Pills
 Others (please list) _____

HABITS AND SYMPTOMS

HABITS:	HEAVY	MODERATE	LIGHT	NONE
Alcohol	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

REVIEW OF SYMPTOMS

Do you have now, or have experienced in the past the following symptoms on a regular basis?
 (Please check)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hi Blood Press | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Itching | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Inf/stone | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Ear Noises | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Slow Heart Beat |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Press | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Neck Pain/Stiff | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nerv/Depress | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Colds | <input type="checkbox"/> Freq. Urination | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain Over Heart | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cramps/backache | <input type="checkbox"/> Headache | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Poor Circulation | |

Tingling/Numbness in:

Arms Elbows Feet Hands Hips Knees Legs Shoulders