



Dr. Adrian D'Amato

Dr. Andria Marie D'Amato

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security number \_\_\_\_\_

Marital Status: (M S D W) Sex: (M F) Driver's License #: \_\_\_\_\_ State \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

What is your current complaint? \_\_\_\_\_

Is this condition due to:  Auto accident  Work injury  Other accident  Illness  Unknown cause

Date symptoms appeared \_\_\_\_\_ Briefly describe what you think caused your pain \_\_\_\_\_

What aggravates your condition?  Standing  Sitting  Walking  Twisting  Lying  Lifting

Are your symptoms:

- Improving
- About the same
- Getting worse
- Comes and goes

List all surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Prescription drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social Habits:

- Tobacco  Alcohol  Coffee

Stress Level:

- Little or no  Minimal  Moderate  Greatly stressed

Exercise:

- No exercise program  Light  Moderate  Strenuous

Physical Activity:

- Sitting 50% or more  Light labor  Heavy labor  Repeated motions

Have you had these symptoms before?

- No  Yes When \_\_\_\_\_

Pregnant:

- No  Yes Due \_\_\_\_\_  N/A

Who is your family doctor? \_\_\_\_\_ Would you like us to send a report to your Family Doctor?  Yes  No

Have you had chiropractic or acupuncture care before? \_\_\_\_\_ When? \_\_\_\_\_ XRays/MRI \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_ Your e-mail address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent to Treat Minor: \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_