

**TANIA MESSINA HOWARD, DC**  
**MARISSA WALLIE, DC**

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Location \_\_\_\_\_ Work phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender F M Height \_\_\_\_\_ Weight \_\_\_\_\_

Marital Status S M D W Race \_\_\_\_\_ Children Y N Ages \_\_\_\_\_

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Specific reason for this visit \_\_\_\_\_

Date of onset \_\_\_\_\_ Sudden (explain) \_\_\_\_\_ or Gradual

Previous history of same or similar problem \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Intensity (on a scale of 1-10, 10 being the worst pain you can imagine) \_\_\_\_\_

Describe the type of symptom (sharp, numb, dull, stabbing, tingling, etc) \_\_\_\_\_

Is it localized or does it radiate to another part? \_\_\_\_\_

Does it bother you constantly, or come and go? \_\_\_\_\_

How does this interfere with your work or home life? \_\_\_\_\_

Are you currently experiencing or have you ever experienced health problems in the following areas (including but not limited to):

Cardiovascular  
Neurological  
Ear/Nose/Throat  
Psychiatric

Respiratory  
Musculoskeletal  
Endocrine  
Immunological

Gastrointestinal  
Ophthalmological  
Peripheral Vascular  
Other \_\_\_\_\_

Is there a family history of any of the above problems? \_\_\_\_\_

Year and type of any surgeries \_\_\_\_\_

Medications on a regular basis \_\_\_\_\_ Allergies \_\_\_\_\_

Year and description of automobiles accidents \_\_\_\_\_

Year and type of other injuries (falls, sports injuries, etc.) \_\_\_\_\_

Other practitioners seen for this particular complaint \_\_\_\_\_

Previous chiropractic care \_\_\_\_\_

What type of exercise do you do regularly? \_\_\_\_\_

Do you currently smoke? Y N Use alcohol? Y N Use recreational drugs? Y N

How do you manage stress? (exercise, yoga, therapy, etc.) \_\_\_\_\_

Do you eat a diet rich in whole foods (whole grains, fish, vegetables, fruits, etc.) \_\_\_\_\_

What color is your urine typically? Clear Pale yellow Medium yellow Deep yellow

How many hours a night do you typically sleep? \_\_\_\_\_

If you work outside the home, what are you physically doing most of the day? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Any other concerns or information that you feel is important that the doctor know \_\_\_\_\_

\_\_\_\_\_

*I understand that chiropractic is not a treatment for any particular condition or disease, but rather a method of detection and correction of spinal misalignments, and acceptance of such treatment does not imply guarantee of results. My signature implies consent for treatment and release of information necessary to coordinate with other health care providers and to process insurance paperwork.*

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

**Thank you for choosing us! We hope that you enjoy your experience here!**