

# Brighton Campus Chiropractors, L.L.C.

Dr. Louis Catapano & Dr. John Sciortino

2024 W. Henrietta Road, Suite 5B

Rochester, NY 14623

(585) 272-7340

*Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.*

## CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Pneumonia
- Rheumatic Fever
- Polio
- Tuberculosis
- Whooping Cough
- Anemia
- Measles

- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Thyroid Disease

- Influenza
- Pleurisy
- Arthritis
- Epilepsy
- Mental Disorder
- Low back pain
- Eczema

**INTAKE:**

- Coffee
- Tea
- Alcohol
- Cigarettes

## CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain/Leg Pain
- Joint Pain/ Stiffness
- Walking Problems
- Difficulty Chewing/ Clicking Jaw
- General Stiffness

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**FEMALES ONLY**

When was your last period?

Are you pregnant? **Yes/ No**

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/ Depression
- Fainting
- Convulsions
- Cold/ Tingling Extremities
- Stress

**C-V-R CODE**

- Chest Pain
- Short of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/ Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**GASTRO-INTESTINAL CODE**

- Poor/ Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Fever

**EENT CODE**

- Vision Problems
- Dental Problems
- Sore Throat
- Difficulty Hearing
- Stuffed Nose

**MALE/ FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pains/ Infection
- Breast Pain/ Lumps
- Prostrate/ Sexual Dysfunction

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **C** under his/her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

*Note: M= Mother, F= Father, S= Sister, B= Brother*

	Age	Age	Age	Age	Age	Age
<b>Arthritis</b>						
<b>Back Trouble</b>						
<b>Bursitis</b>						
<b>Disk Problems</b>						
<b>Headaches</b>						
<b>Migraine</b>						
<b>Neuritis</b>						
<b>Pinched Nerve</b>						
<b>Scoliosis</b>						
<b>Nervousness</b>						
<b>Emotional Problems</b>						
<b>Epilepsy</b>						
<b>Insomnia</b>						
<b>Asthma-Hay Fever</b>						
<b>Cancer</b>						
<b>Constipation</b>						
<b>Diabetes</b>						
<b>Emphysema</b>						
<b>Heart Trouble</b>						
<b>High Blood Pressure</b>						
<b>Kidney Trouble</b>						
<b>Sinus Trouble</b>						
<b>Stomach Trouble</b>						
<b>Other:</b>						

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_