Dr. Jessica Nardone, Chiropractor

2202 W. Magnolia Blvd.
Burbank, CA 91506
drjessicanardone@gmail.com
724-494-6284

Patient History

Name_____ Date_____
Address_____ State_____ Zip_____
H. Phone (_____)_____ W. Phone_____ Date of Birth_____ Age_____
Referred by_____Social Security #_____
Occupation_____Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____ Spouses Occupation_____
Have you ever received Chiropractic Care? Yes No

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding your Birth Process:			
Was the delivery long/difficult?	Y N		
Forceps or extraction used?	Y N		
Cesarean/ C-Section?	Y N		
Breach/ cephalic?	Y N		
Home birth?	Y N		
Hospital birth?	Y N		
Mother given drugs during delivery?	Y N		
Was labor induced?	Y N		
2. Growth and Development/ Childhood:			
Were you breast fed?	Y N		
Health education?	Y N		
Childhood illnesses?	Y N		
Ear infections/ Colic/ Asthma?	Y N		
Attention Deficit?	Y N		
Antibiotics?	Y N		
Drugs, prescription, OTC, recreational?	Y N		
Surgery?	Y N		
Hospitalizations?	Y N		
Sports or other physical activities	Y N		
Injuries during sports?	Y N		
Auto accidents?	Y N		
Did you have other traumas?	Y N		
Did you ever break any bones?	Y N		
3. Current Health Habits:			
Did/do you smoke?	Y N		
Did/do you drink alcohol?	Y N		
Diet, do you eat healthy foods?	Y N		
Have you been in accidents/trauma?	Y N		
Have you had surgery?	Y N		
Drugs, prescription, OTC, recreational?	Y N		
Dental problems?	Y N		
Eye problems?	Y N		
Hearing problems?	Y N		
Exercise regularly?	Y N		
Did/do you have occupational stress?	Y N		
Drive? Daily time spent driving	Y N		
Physical stress?	Y N		
Emotional/Mental stress?	Y N		
Hobbies/Sports injuries?	Y N		
Do you sleep well, hours of sleep?	Y N		
Sleeping posture? ☐ side ☐ stomach ☐ back			

Symptoms and Present State of Health

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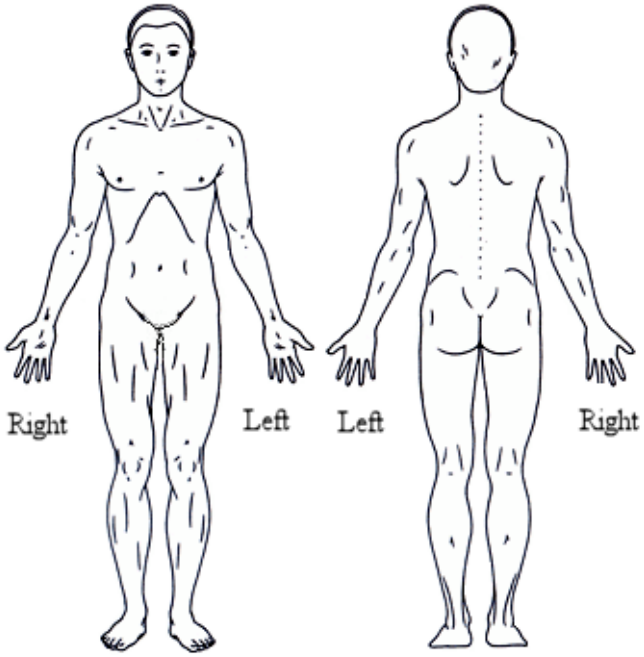
Present Complaint/Reason for Seeking Care in this Office:
Major_____
Pain or Problem started on_____
Pains are: ☐Sharp ☐Dull/ Ache ☐Constant ☐Intermittent ☐Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: ☐Same ☐Better ☐Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

☐Headaches	☐Pain in Hands or Arms	☐Chest Pains
☐Neck Pain	☐Numbness in Hands or Arms	☐Heart Attack
☐Sleeping Problems	☐Pain in Legs or Feet	☐High Blood Pressure
☐Low Back Pain	☐Numbness in Legs or Feet	☐Stroke
☐Nervousness	☐Fatigue	☐Cancer
☐Tension	☐Depression	☐Painful Urination
☐Irritability	☐Lights Bother Eyes	☐Diabetes
☐Dizziness	☐Loss of Memory	☐Diarrhea
☐Pain Between Shoulders	☐Shoulder Pain	☐Constipation
☐Neck Stiff	☐Sinus	☐Stomach Upset
☐Joint Swelling	☐Shortness of Breath	☐Heartburn/Reflux
☐Fever	☐Asthma	☐Weight Loss
☐Loss of Balance	☐Allergies	☐Loss of Smell or Taste
☐Ringing in Ears	☐Cold Hands	☐Menstrual Cramps
☐Jaw/TMJ Problems	☐Cold Feet	☐Menopause

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Are you under medical care for any condition?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	☐	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐	☐

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature_____Date_____