Dr. Luke Pietrantone
Dr. Michelle Pietrantone

121 Elm Street
East Aurora, NY 14052
Phone: 716-655-1421
drlpietrantone@aol.com

HEALTH QUESTIONAIRE

Personal Information

Full name _____Name you wish to be called_____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M / F

Insurance Company: _____

Occupation: _____Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to my office?

_____

_____

_____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition?_____

_____

Have you had this or similar conditions in the past?_____

What makes it better? _____Worse? _____

Is the condition getting worse? _____Constant? _____

Worse at a certain time of day?_____

Is this condition interfering with: Work? _____Sleep? _____ Activity? _____Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

_____

_____

_____

Health History

List other current health issues & problems:_____

_____

_____

_____

List other practitioners seen, treatments, self-care activities, and results: _____

_____

_____

_____

List illness you have had not previously mentioned, if any:_____

_____

List all surgeries you have had, with dates and results: _____

_____

_____

Have you ever been in an accident or seriously injured? (if so, please describe)_____

_____

_____

Do you have any dental or TMJ problems? Y N (if so, please describe)

_____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N

(if yes note which teeth) _____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment): _____

_____

_____

_____

List all medications and other substances (i.e.: foods) to which you are allergic:

_____

_____

_____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____ Children_____

Grandparents _____ Brothers _____ Sisters_____

General

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate: _____

_____

_____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N

* Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have nightsweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____

* Prostate Exam _____*Other_____

Pain Questionnaire

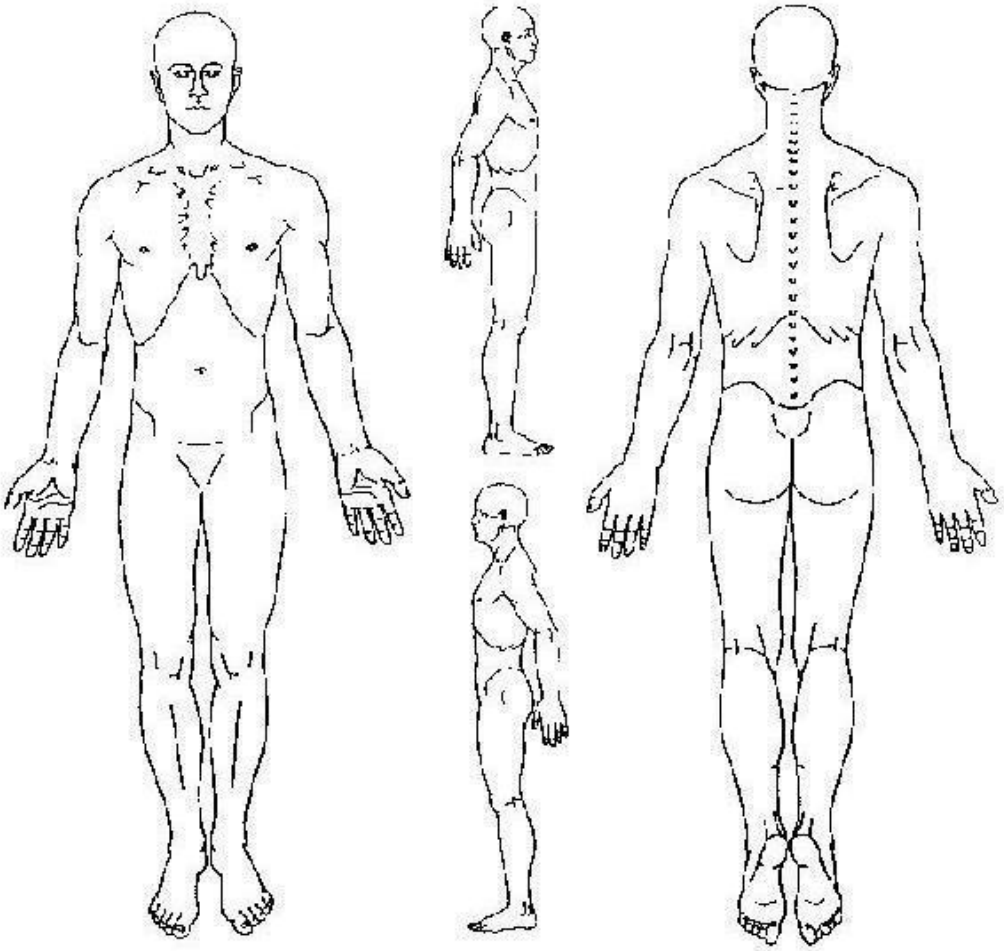
(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

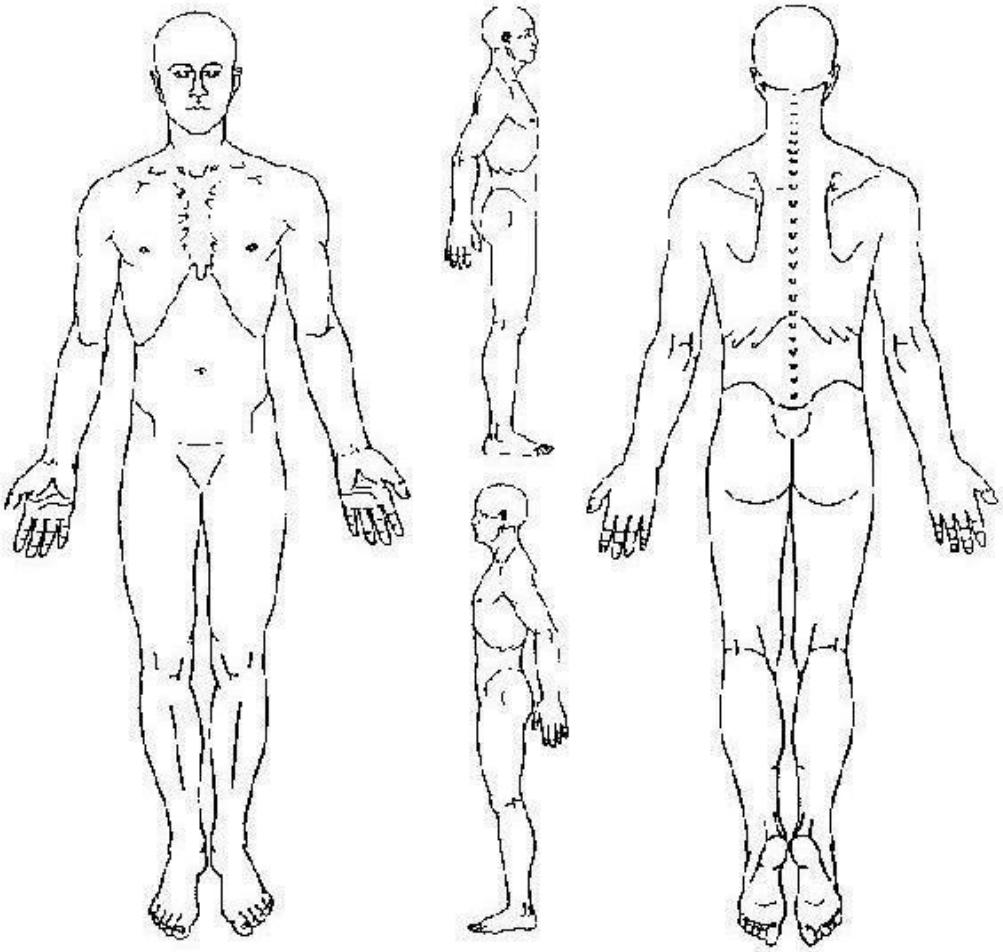
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache B=Burning N=Numbness O=Other P=Pins & Needles S=Stabbing T=Throbbing



History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

□ Low energy-fatigue
□ Weakness
□ Fever-Chills
□ Headaches
□ Lack of Sleep
□ Reduced Mental Acuity

SKIN

□ Dry skin
□ Itching
□ Varicose veins
□ Cold or canker sores/fever blisters
□ Boils
□Hives
□Rashes
□ Sores
□ Change in your skin/nails

EYES

□ Cataracts/Glaucoma
□ Eye pain
□ Double vision
□ Far or near sightedness
□ Flashing lights
□ Spots, specks, or floaters

EARS

□ Ear Discharge/Excessive Wax
□ Earaches or Infections
□ Hearing Loss
□ Ringing/Tinnitus
□Vertigo/dizziness

NOSE/SINUS

□ Sinus congestion □
□ Frequent colds/infections □
□ Nosebleeds □

NECK

□ Goiter
□ Lumps
□ Pain/Stiffness
□ Swollen Glands

RESPIRATORY

□ Asthma
□ Bronchitis
□ Cough
□ Pneumonia
□ Tend to Hold Breath
□ Wheezing
□ Sputum
□ Trouble Breathing w/Exercise

CARDIAC/VASCULAR

□ Arrhythmia
□ Chest Pain
□ Heart Trouble
□ Murmur
□ High Blood Pressure
□ Palpitations
□ Shortness of Breath
□ Swollen Feet or Lower Legs
□ Racing or Pounding Heart
□ Blood Clots
□ Leg Cramps
□ Poor Circulation

MOUTH/THROAT

□ Dentures
□ Tooth decay
□ Frequent sore throats
□ Grind teeth at night
□ Hoarse voice/frequent loss of voice

GASTROINTESTINAL

□ Belching
□ Flatulence/Gas
□ Black or Tarry Stools
□ Blood in Stool
□ Change in Stool
□ Colitis
□ Constipation
□ Diarrhea
□ Distention
□ Excessive Hunger
□ Heartburn
□ Food Intolerance
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Poor Appetite
□ Stomach Pain
□ Trouble Swallowing
□ Vomiting

HEMATOLOGIC

□ Anemia
□ Bruise easily

URINARY

□ Frequent urination
□ Blood in urine
□ Incontinence
□ Painful urination
□ Urinate more than once at night

NEUROLOGIC

□ Blackouts
□ Fainting
□ Numbness
□ Paralysis
□ Dizziness
□ Tremors
□ Seizures

PSYCHOLOGICAL

□ Anxiety
□ Depression
□ Insomnia/Hard to Fall Asleep
□ Nervousness
□ Poor Memory/Forget Quickly
□ Violent Thoughts
□ Suicidal Ideas
□ Tend to Worry

ENDOCRINE

□ Diabetes
□ Excessive Thirst or Hunger
□ Excessive Sweating
□ Lack of Sweating
□ Heat or Cold Intolerance
□ Thyroid Problem
□ Hair Loss
□ Dizzy when Rising Quickly
□ Excessive Weight Loss
□ Excessive Weight Gain

MUSCLES & JOINTS

□ Arthritis
□ Tendonitis
□ Bursitis
□ Gout
□ Trouble with/poor posture
□ Chronic pain
□ Pain with specific movement(s)
□ Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc…)
□ Pain, tenderness, or numbness in:
- Neck
- Shoulders
- Arms
- Elbows
- Wrist/hands
- Upper back
- Lower back
- Hips
- Knees
- Feet/ankles

**MALES ONLY: SEXUAL/HORMONAL

□ Prostate problems
□ Hernia
□ Erection trouble
□ Discharge
□ Premature ejaculation
□ Sexually transmitted disease
□ Testicular lump/pain
□ Itching/rashes
□ Vasectomy

**FEMALES ONLY:

□ Bleeding between Periods
□ Decreased Sexual Interest
□ Pain with Intercourse
□ Discharge
□ Itching
□ Sores
□ Yeast Infections
□ Sexually Transmitted Disease
□ PMS
- Breast Tenderness
- Cramping/Bloating
- Back Pain
- Over-Emotional
- Tired/Fatigue
- Other Pain
- Other Symptoms

□ Age at First Period_____
□ Number of Days in Cycle_____
□ Usual Length of Period_____
□ Start of Last Period Date_____
□ Number of Pregnancies_____
□ Number of Deliveries_____
□ Complications with Pregnancies _____
□ Birth Control Method_____

DIET HISTORY

How much do you drink each day (8oz): Water:____ Juice: _____ Soda Diet: ____ Soda Regular: ____

Coffee: Regular: ____ Decaf: ____ Tea: Regular:____ Tea Sweet :____ Energy Drinks/Other:_____

List oils or fats that you use in cooking: _____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N

Describe:

_____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

_____

What foods do you dislike? _____ What is/are your favorite food(s)?_____

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods Spicy foods Sour foods Cereals Dairy
Other individual _____

*Do you use: (circle) butter margarine shortening coconut oil * Do you eat organic foods? Y N

*Do you know what partially hydrogenated fats are? Y N _____If yes, do you eat them? Y N

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What do you usually eat for snacks (in between meals and/or before bed)? _____

What foods do you eat a lot of (at least once a day, every day)? _____

How many bowel movements do you have per day? _____

A Bit More ----

*Type of sport/activity/exercise routine you participate in:

*Hours you train/exercise average per week: _____ *Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style)_____

OFFICE POLICIES

Dr. Luke Pietrantone and Dr. Michelle Pietrantone are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses, only nutritional advice or support. It is understood that this advice and support is provided for general health and is not offered as treatment for a specific disease or illness.

Financial

Dr. Luke and Dr. Michelle Pietrantone do not participate (not in-network) with any insurance. We will provide you with a receipt with the appropriate diagnosis codes and procedure codes upon request to the front desk. We are unable to fill out any paperwork for approvals, authorizations, etc. Patients may opt to submit this to their insurance on their own. However, any reimbursement depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit. We accept all major credit cards, FSA cards, HSA cards, cash and checks.

All supplements and additional supplies are the patient's responsibility and payment is due at the time of the visit.

Please give our office at least 24 hours advance notice for any cancellation. If 24 hours notice is not given, 50% of the appointment fee will be billed you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

Emergencies

If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, please go to the Emergency Room or dial 911.

Confidentiality

We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family, and insurance companies will require your written consent.

By signing below you understand and agree to the above office policies including the 24-hour cancelation fee. Bring this form to your first appointment. We cannot begin treatment without it.

Name(signed)_____ Date_____

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