Marinelli Methods - Health Form

Patient Name _____

Birthdate_____ Current Age _____ Male___ / Female___

Contact number _____ cell or home

Email Address _____

Home Address _____

Occupation _____

Referred by _____

Emergency Contact:

Name_____ Phone _____

Relationship to Patient _____

COMPLAINT HISTORY

Describe your current complaint and how the problem began: _____

_____

How long have you had this condition? _____ ***Date of onset:*** _____

How would you describe pain?

___Sharp ___Soreness ___Throbbing ___Tingling ___Dull ___Stiffness
___Spasm ___Burning ___Ache ___Weakness ___Numbness ___Shooting

How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Moderate pain) (Terrible/unbearable pain)

How often is the pain present? (Circle one)

Constant (81-100%) Frequent (51-80%) Occasional (25-50%) (Intermittent 25% or less)

Since the problem began, is the pain:

Getting Worse ___ Getting Better ___ Staying the same ___

How did the problem begin?

___An auto accident ___Work related accident ___Other type of accident
___Gradual ___Sudden ___No specific reason
Explain: _____

_____

What makes your problem better?

___Nothing ___Walking ___Standing ___Sitting ___Moving around/exercise
___Lying down ___Inactivity

What makes your problem worse?

___Nothing ___Walking ___Standing ___Sitting ___Moving around/exercise
___Lying down ___Inactivity

Are you taking any medications? Yes ___ No ___

If yes, please describe: _____

Were you previously treated for an earlier occurrence of this same condition? Yes __ No __

If yes, by whom? MD __ Chiropractor __ Physical therapist __ Other: _____

What were the approximate dates, type of treatment and the results? _____

_____

What is your physical activity at work?

___Mostly sitting ___Light manual labor ___Moderate manual labor ___Heavy manual labor

Notes: _____

_____

_____

_____

_____

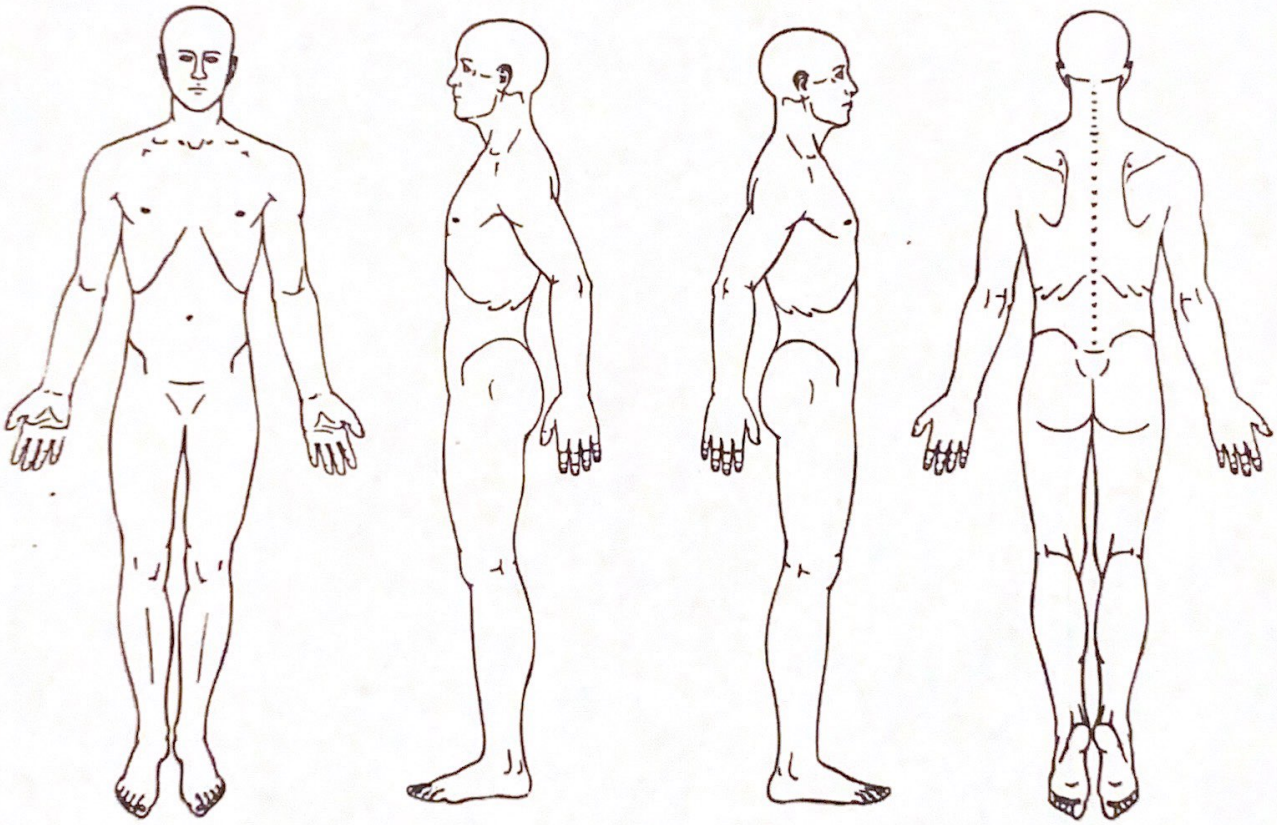
_____

PAIN ASSESSMENT

Name: _____ Date: _____

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



3. Next to each area marked above, please note the intensity of pain.

No Pain		Minimal		Tolerable, but hinders activities		High - 50% of activities impaired		Extreme - most activities impaired		Unbearable
0		1	2	3	4	5	6	7	8	9

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Name_____ Phone_____	

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Charles A. Marinelli, D.C., P.A.

50 Mt. Prospect Avenue
Clifton NJ 07013

170 Kinnelon Road
Kinnelon, NJ 07405

Consent Form

I, _____ certify that Dr. Marinelli does not claim to cure any illness or disease. I further understand that some procedures used in this office are not considered medically diagnostic and therefore do not diagnose disease. Dr. Marinelli does use various standard medically proven diagnostic measures and modalities (x-ray, MRI, blood tests, blood pressure, heart rate variability, etc.) to evaluate the patients' condition.

Treatments consist of low force adjustments or manipulations to the spine or extremities. They are designed to relieve or reduce your symptoms or complaints.

I understand that I am to continue all medications as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I authorize permission to this office to request copies of my bloodwork, x-rays, etc. from other physicians; to release any information pertinent to an authorized representative for review.

I acknowledge that I am responsible for any covered or non-covered services I receive as Dr. Marinelli is a non-participating provider.

I understand that a fee will be charged for any missed appointments if notice has not been given in 24 hours before my appointment.

I have read or have had read to me the above statements and have had the opportunity to ask questions about the content, and by signing below I agree to the terms and procedures.

_____ Date _____

Patient's Signature

_____ _____

Name of Minor Relationship to Minor