Noel Cappillo DC
148 Linden St
Wellesley MA 02481

Confidential Health History

Name: _____ Date:_____

Home Address: _____ Birthdate:_____

_____

Preferred phone number:_____ ___cell ___work ___home

Alternate phone number:_____ ___cell ___work ___home

Occupation/student status:_____ Employer:_____

Age:___ Gender:_____ Height:_____ Weight: _____ Name you prefer to be called:_____

Relationship status:___single___married __live-in partnership___separated ___divorced___widowed

Name of spouse/partner/guardian if a minor: _____

Number of Children:___Who referred you to our office (so we can thank them)?:_____

Person to contact in case of emergency (name/number): _____

Name of Insurance Co: _____

Insured's name: _____ Insured's birthdate: _____

Please describe the primary condition for which you seek treatment at this office:

_____

When did this condition start? _____

Is your condition getting progressively worse? Yes____ No ____ Constant ____ Comes and goes _____

Is your condition interfering with your: Work _____ Sleep _____ Daily routine _____ Exercise _____

List any doctors seen for this: _____

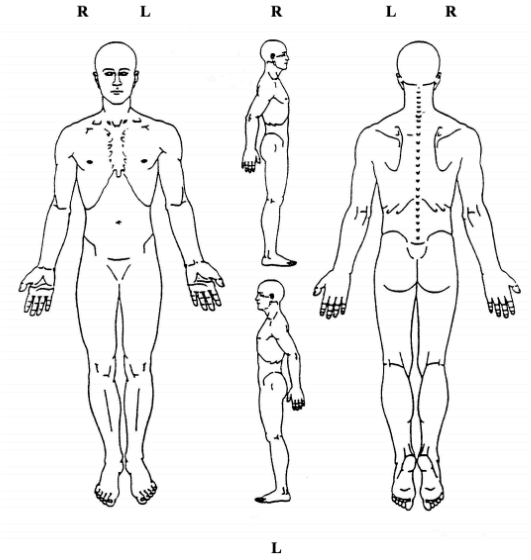
List any diagnoses or treatment received: _____

Have you had any relatives with a similar condition? _____

Do you use any orthotic devices? Cane ____ orthotics ____ heel lift ____ other _____

Name: _____ Signature: _____

Please mark your areas of pain on the figure below:



Lifestyle: Amount daily

Alcohol_____

Coffee_____

Tobacco_____

Water _____

Exercise_____

Sleep _____

Glasses/contacts?_____

Allergies: _____

_____

List any accidents: _____ **Dates:** _____

Broken bones: _____ **Dates:** _____

Serious Falls/injuries: _____ **Dates:** _____

Additional information pertinent to health: _____

_____

List and past or present illnesses or medical problems:

_____

_____

List any surgeries: _____ Dates: _____

_____ Dates: _____

_____ Dates: _____

List any X-rays, MRI and/or CT scan taken in the last 10 years:

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

Circle any of the symptoms listed below that you have experienced:

Fatigue, weight loss, insomnia, blurry vision, change in vision, ear pain, hearing loss, throat pain, hoarseness, sinus pain, nasal congestion, cough, shortness of breath, wheezing, chest pain, palpitations, vertigo, nausea, diarrhea, constipation, bloating, abdominal pain, reflux, incontinence, joint pain, muscle pain, headache, numbness, tingling, dizziness, muscle weakness, sciatica, hair loss, dry skin, hot flashes, depression, anxiety.

Name: Signature: