

10. 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? _____

11. What is your physical activity at work?
 Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

12. Do you exercise?
 No regular exercise 1-2 times a week 3-4 times a week 5-7 times a week
 Cardiovascular Stretching Weight machine Free weights
 Sports _____ (type)

13. What is your present general stress level?
 No stress Minimal stress Moderate stress Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?
 No effect Have some limited physical restriction, but can function
 Need some assistance with daily activities Cannot work
 Can not function without assistance Totally disabled

Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the line indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	_____	_____	High blood pressure.....	_____	_____
Shoulder pain	_____	_____	Heart condition	_____	_____
Arm/elbow pain.....	_____	_____	Respiratory condition	_____	_____
Hand pain.....	_____	_____	Digestive problems	_____	_____
Upper back pain.....	_____	_____	Kidney/bladder problem	_____	_____
Lower back pain.....	_____	_____	Menstrual problems	_____	_____
Pain in upper leg or hip	_____	_____	Brest soreness/lump.....	_____	_____
Pain in lower leg or knee	_____	_____	Sinus conditions	_____	_____
Pain in ankle or foot	_____	_____	Allergies/asthma	_____	_____
Jaw pain.....	_____	_____	Cancer	_____	_____
Swelling/stiffness of joints.....	_____	_____	Stroke	_____	_____
Headaches	_____	_____	Excessive weight loss/gain.....	_____	_____
Dizziness	_____	_____	Skin condition	_____	_____
Fainting spells.....	_____	_____	Arthritis.....	_____	_____
Convulsions.....	_____	_____	Diabetes.....	_____	_____
General prolonged fatigue.....	_____	_____	Prostrate condition.....	_____	_____
Condition of uterus/ovaries.....	_____	_____			

Comments: _____

Tobacco use:
 None Past Present Occasional Moderate Heavy

Alcohol use:
 None Past Present Occasional Moderate Heavy

Caffeine use: (coffee, tea, soft drinks)
 None Past Present Occasional Moderate Heavy

Pregnancy:
 None Past Present

Surgical procedure:
 None Past Please list: _____

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Please circle pain levels 0-10 (10 being most painful) and circle type of pain.

Pain Levels: **Neck Pain:** 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Buttocks: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

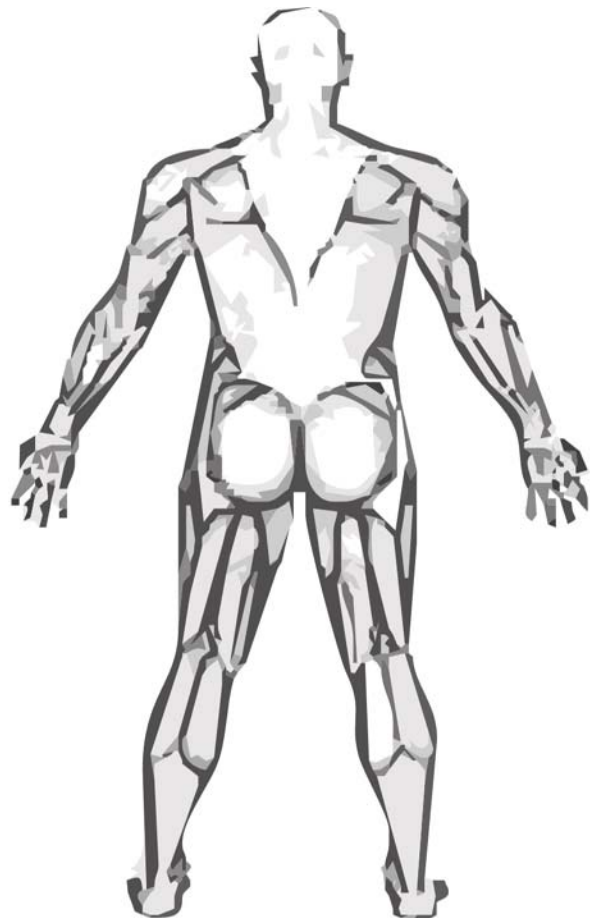
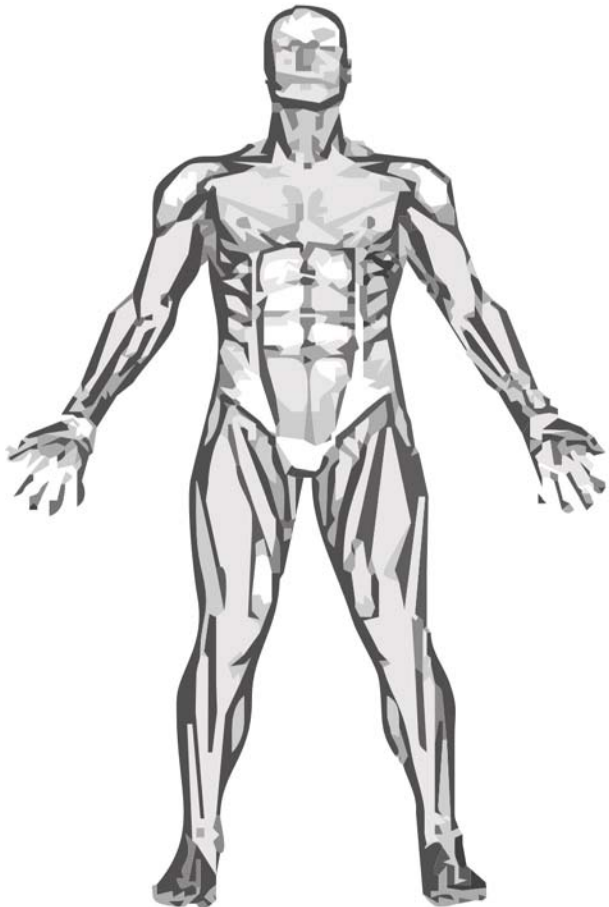
Pain Levels: **Mid Back:** 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Hip Pain: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

Pain Levels: **Low back:** 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Shoulder: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

Please mark "X" where you have pain on picture below



Patient Signature: _____