CORDIMA CHIROPRACTIC CENTER

Dr. Christopher Cordima
707 Broadway
Somerville, MA 02144
(617) 629-2600
www.somervillechiropractor.com

1. Please enter your information.

First Name: ______ Middle Initials: ______ Last Name: ______

Is This Your Legal Name
- Yes
- No

Date of Birth: ______

Gender:
- Female
- Male

Spouse Name ______

Marital Status:
- Single
- Married
- Domestic Partner
- Separated
- Divorced
- Widowed

Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

Home Phone: ______ Mobile Phone: ______ Email: ______

Preferred contact method:
- Mobile Phone
- Home Phone
- Work Phone
- Email

Occupation ______

Retired
- Yes
- No

2. Power of Attorney

Has Power of Attorney been assigned that limits your ability to make your own decisions while conscious?

______

Who in your family is involved in your health decisions? (Daughter, Son, Spouse, etc.)

______

3. Chose clinic because / Referred to clinic by:

- Dr. Referral
- Internet
- TV
- Family/Friend
- Mailer
- Radio
- Emergency Room
- Facebook
- Email
- Other

If other, please specify:

______

4. Type of Insurance

- None
- Mass Health
- Medicare
- BCBS
- Aetna
- Cigna

- Tufts
- Car Accident Insurance
- HCHP
- Other

If other, please specifiy:

____

5. Height & Weight

Height: feet ____________ Height: inches ____________ Weight: pounds ____________

6. Health History

General:
- ☐ Fatigue, Tiredness
- ☐ Weakness
- ☐ Sedentary Lifestyle
- ☐ Generalized Pain
- ☐ Poor wound healing

Neurological:
- ☐ Poor Balance
- ☐ Numbness of Face / Arm / Leg
- ☐ Peripheral Neuropathy
- ☐ Stroke or Mini-Stroke
- ☐ Burning Pain
- ☐ Restless Leg
- ☐ Prickling/Tingling Feeling
- ☐ Muscle Cramping

Psychiatric:
- ☐ Alzheimer's
- ☐ Confusion (Abnormal)

Respiratory:
- ☐ TB
- ☐ Chronic Obstructive Disease
- ☐ Wheezing
- ☐ Chronic Cough Asthma

Cardiac:
- ☐ Angina (Chest Pain)
- ☐ Past heart attacks
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Pacemaker
- ☐ Defibrillator

Vascular:
- ☐ Blood Clots in Legs (Deep or Superficial)
- ☐ Amputation of Toes
- ☐ Amputation of Feet or Legs
- ☐ Peripheral Vascular Disease
- ☐ Ulcers of Lower Legs

Gastrointestinal:
- ☐ Ulcer
- ☐ Stool Changes
- ☐ Indigestion
- ☐ Colon Polyps
- ☐ Diverticulitis

Genitourinary:
- ☐ Current Dialysis
- ☐ Urgency of Urine
- ☐ Renal Transplant
- ☐ Erectile Dysfunction

Blood & Lymph System:
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Blood Disease
- ☐ Transfusions
- ☐ Leukemia
- ☐ Bone Marrow Test
- ☐ Long Term Coumadin Use
- ☐ Blood Clotting Problems/Blood Clots
- ☐ Multiple Myeloma

Eyes, Ears, Nose & Throat:
- ☐ Vertigo

Musculoskeletal:
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Degenerative Disc
- ☐ Bulging Disc
- ☐ Herniated Disc
- ☐ Pinched Nerve
- ☐ Spinal Stenosis
- ☐ Sciatica ☐ Leg Pain ☐
- ☐ Joint Replacement

Skin:
- ☐ Malignant Melanoma
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Fungal infections
- ☐ Non-healing Sores

Endocrine:	Abnormal Organs:	Hands	Feet
☐ Thyroid problems	☐ Hepatitis	☐ Hand Pain	☐ Foot Pain
☐ Diabetes – Type	☐ Cirrhosis(Liver)	☐ Arthritis in Hands	☐ Arthritis in Feet
☐ Diabetes – Type 2	☐ Gallbladder Disease	☐ Hand/Wrist Surgery	☐ Foot Surgery
☐ Excessive Thirst or Urination		☐ Hand Numbness	☐ Foot Numbness
		☐ Carpal Tunnel Syndrome	☐ Morton's Neuroma
			☐ Plantar Fasciitis

Check Areas you have experienced Pain, Numbness, Tingling, or Stiffness in the last 6 months
☐ Left Knee ☐ Right Knee ☐ Feet ☐ Hands ☐ Back ☐ Neck ☐ Shoulder ☐ Hip

____

7. **Social History**

Do You Smoke ______________
○ Yes ○ No

Do you drink? ______________
○ Yes ○ No

Do you exercise regularly? ______________
○ Yes ○ No

8. **Primary Doctor Information**

Who is your primary doctor? ______________

Phone Number? ______________

When were you last seen there? ______________

May we send them updates on your treatment/condition?
○ Yes ○ No

9. **Have you had any cancers?**

○ Yes ○ No

If yes, for how long?

____

10. **STATIN: Are you currently taking a Statin medication? (Cholesterol Med)**

○ Yes ○ No

If yes, for how long

____

11. **Do you have a list of your medications?**

○ Yes ○ No

12. **What is your major complaint?**

____

____

13. **How would you rate your average pain over the past week for this problem?**

0 No Pain - 10 Worst Possible Pain

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

14. **Before you began having this problem was there an earlier condition, accident, injury or surgery that could have brought this problem about?**

○ Yes ○ No

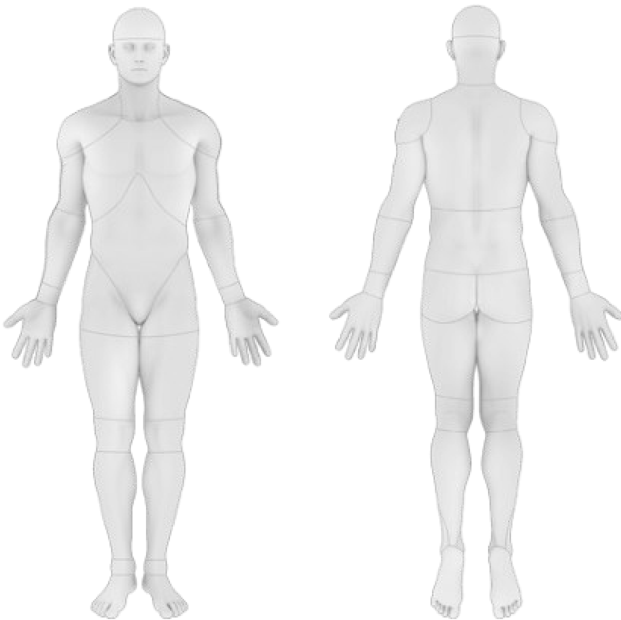
15. **How long have you had this problem?**

____

16. **Have your symptoms?**

○ Improved ○ Worsened ○ Stayed the same

17. **Indicate on the body where you are currently having symptoms**



18. **Please describe the quality of the pain**

- ☐ Aching Pain
- ☐ Cramping
- ☐ Throbbing Pain
- ☐ Pins & Needles Pain
- ☐ Tiredness
- ☐ Electric Shocks
- ☐ Numbness
- ☐ Stabbing Pain
- ☐ Swelling
- ☐ Dead Feeling
- ☐ Heavy Feeling
- ☐ Hot Sensation
- ☐ Tingling
- ☐ Sharp Pain
- ☐ Burning
- ☐ Cold Hands/Feet

Other

____

19. **Is your balance/walking ability affected?**

○ Yes ○ No

Are you using a cane or walker?

○ Yes ○ No

If yes, please describe

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20. How often are you made aware of your neuropathy problem?

- ○ Occasionally (25% of the time)
- ○ Intermittently (50% of the time)
- ○ Frequently (75% of the time)
- ○ Constant (90-100% of the time)
- ○ Constant (with varying intensity)

21. What time of the day is the condition the worst?

○ Morning ○ Afternoon ○ Evening ○ Night - Sleep Time

22. On a scale of 0-10 (10 being unbearable, 0 being pain free), please rate your symptoms in the following

WITH medication

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

WITHOUT medication

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

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23. Have you seen a M.D., P.T., or a D.C. for this problem?

○ Yes ○ No

24. Primary Care Physician Information or other M.D., P.T., or D.C. for this problem

	Doctor's Name	Specialty	Year(s) Seen
1			
2			
3			

More information

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25. List the prescription drugs you are currently taking

	Medication	Since When? or For How Long?	Effective?
1			
2			
3			

26. List all nutritional supplements (vitamins, herbs, homeopathics, etc.)

	Supplement	Since When? or For How Long?	Effective?
1			
2			
3			

27. List ALL allergies/sensitivities to medication, food, and other items here:

____

____

28. In spite of the fact that you're not a neuropathy specialist, you are in fact the person who knows more about your condition than anyone else. In your own words, what do you think the problem is?

____

____

29. What is your main concern about your symptoms?

____

____

30. Is this condition interfering with any of the following (check all boxes that apply)

- ☐ Work ______
- ☐ Sleep ______
- ☐ Daily Routine ______
- ☐ Household tasks/chores ______
- ☐ Walking ______
- ☐ Standing ______
- ☐ Shopping ______
- ☐ Family Time ______
- ☐ Sitting ______
- ☐ Recreational Activities ______
- ☐ Leisure/Social Activities ______

List any other activities or loss here

____

31. What kind of treatments have you received?

- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Surgery
- ☐ Nerve Block/Injection
- ☐ Stem Cell
- ☐ Pain Medications
- ☐ Tylenol
- ☐ Gabapentin
- ☐ Neurontin
- ☐ Ibuprofen
- ☐ Cymbalta
- ☐ Lyrica
- ☐ Aleve
- ☐ Creams
- ☐ Orthotics

Other:

____

32. Did any of these treatments work? If so, which one(s)?

- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Surgery
- ☐ Nerve Block/Injection
- ☐ Stem Cell
- ☐ Pain Medications
- ☐ Tylenol
- ☐ Gabapentin
- ☐ Neurontin
- ☐ Ibuprofen
- ☐ Cymbalta
- ☐ Lyrica
- ☐ Aleve
- ☐ Creams
- ☐ Orthotics

Other:

___

33. Is there anything that you currently do that makes it feel better?

○ Yes ○ No

If so, what?

___

34. Are there any activities that make it worse?

○ Yes ○ No

___

35. Overall, has your condition been progressing and restricting you from doing the things you love?

○ Yes ○ No

36. Since your neuropathy has progressed, what three things has it caused you to miss the most?

1. ___
2. ___
3. ___

37. How serious do you feel the problem is?

- ☐ Minimal (annoying but causing no significant limitation)
- ☐ Slight (tolerable and causing minimal limitation)
- ☐ Moderate (sometimes tolerable, sometimes causing definite limitation) Severe (causing significant limitation)
- ☐ Extreme (causing nearly constant limitation)

38. If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

39. On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

____

40. Is there anything else that you would like to tell the doctor before your visit?

____

____

41. If you would like us to help verify your insurance before your appointment you can upload a copy of your License or I.D. and your Insurance Card? We can also assist you with this upon your arrival.