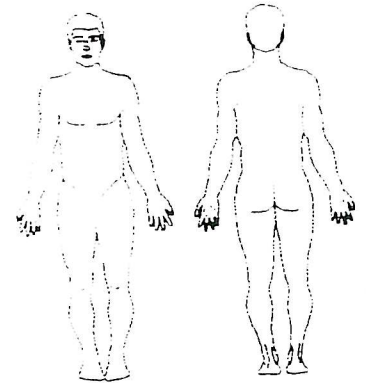


Dr. Donald A. Ozello DC
Championship Chiropractic
8871 W. Flamingo Rd. Suite 202
Las Vegas, NV 89147
702 286-9040

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Secondary Phone: _____ E-mail: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Care Physician Name: _____ PCP Phone: _____
 How were you referred to this office? _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:



DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):
 [_____]
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Unbearable Pain

How often are your symptoms present? 0 - 25% 26 - 50% 51 - 75% 76 - 100%

Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? NO YES Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you:

- | No | Yes | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Infection or Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure/Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (Date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor |

None Apply

- | No | Yes | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Food Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

Signature: _____ Date: _____