elle E. Ryan, DC	Form		Occupation:		Pł	none:	
					DOB:		
e (Last. Firs	t):				Date:		_ 0-
ne (Last, First): wn Allergies:							
vii Alleigies					rently experiencing		
				are carrently experie	chenig		
Genera			/ Bone / Joint	Cardio	vascular		
,	Depression		Chronic Pain		High Blood Pre	essure	/
	Dizziness		Where:		Low Blood Pre	essure	
	Fainting		How Long:		Palpitations		
	Fatigue				Pacemaker		
	Headaches		Fracture/Dislocation		Bleeding Disor	rder	
	Loss of Sleep		Arthritis				
	Mental Illness		Spinal Deformity		High Cholester		
	Tremors		Joint Pain	П	Stroke		
	Weight Gain/Loss		Other	П	Circulation Pro	hlams	
	Head Trauma/Inju				Anemia	Doicins	
Respira	-	['] Gastro	intestinal	. \Box	Arterioscleros	ic	
	Chest Pain		Ulcer/Upper GI Blee	ding \Box			
	Chronic Cough		Lower GI Bleeding		·		
_	_		Hemorrhoids	Genito	ourinary		
	Difficulty Breathing	-	Frequent Diarrhea		Urinary Tract I	Infection	
	Respiratory Infecti	on _	Constipation		Bladder Infect	ion	
	Wheezing	П	Abdominal Pain		Kidney Stone		
	Asthma		Bloody/Tarry Stool		Painful Urinati	ion	
	Bronchitis		bioody/ railly Stool				
					Increased Fred	guency of	
	Emphysema		Vomiting	_	Increased Fred		
	Pneumonia		Vomiting Nausea		Change in Flov	w/Force of	
	Pneumonia Other		Vomiting Nausea		Change in Flow Other	w/Force of	
	Pneumonia Other lications (Prescripti	on, Over-the-Co	Vomiting Nausea Other		Change in Flow Other Other	r Conditions Alcoholism Cancer Chicken Pox	
Med	Pneumonia Other lications (Prescripti	on, Over-the-Co	Vomiting Nausea Other unter, Vitamins, Herbs	S, Supplements)	Change in Flow Other	r Conditions Alcoholism Cancer Chicken Pox Cold Sores	
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Med	Pneumonia Other lications (Prescripti	on, Over-the-Co	Vomiting Nausea Other unter, Vitamins, Herbs	S, Supplements)	Change in Flow Other Other	r Conditions Alcoholism Cancer Chicken Pox Cold Sores Diabetes Epilepsy	
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Med Name Comm Habits Smoking Alcohol Exercise	Pneumonia Other dications (Prescripti Dose/F nents (further expla	packs/day Drinks/wk	Vomiting Nausea Other unter, Vitamins, Herbs Reason the above): Date	S, Supplements) Doctor	Other Other surgeries, drug/a	r Conditions Alcoholism Cancer Chicken Pox Cold Sores Diabetes Epilepsy Goiter STD	
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Finger Lakes Chiropractic Danielle E. Ryan, DC Medical Intake Form

Patient Signature __

Present complaint and reason for seeking care:
How long have you had this problem?
Is this problem getting worse? No Yes
Have you seen anyone else regarding this complaint? \Box No \Box Yes
If so, whom?
Have you received any medical tests for this conditions (X-Rays, blood tests, etc)? No Yes
Other health problems you may have and would like us to address:
Please draw location of your presenting complaint on the body outlines below
Sharp/Stabbing Numbness Burning Aching Pins/Needle Other
////// OOOO XXXX
R L L Worst Pain
No Pain Possible
Please mark on the level of your pain on the scale above
Is there anything else you would like us to know that may help us with your visit? I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Date_