DR. DAYNA D'ACIERNO DR. MARK BUTLER

DLD Wellness, LLC

856 GOLD HILL RD; STE 103 FORT MILL, SC 29708 803-802-6637

CONFIDENTIAL PATIENT INTAKE QUESTIONNAIRE

NAME_____ AGE_____ DATE OF BIRTH_____

STREET ADDRESS_____ CITY, STATE, ZIP _____

CELL PHONE_____ EMAIL_____ OCCUPATION_____

HEIGHT_____ WEIGHT_____ SPOUSE'S NAME_____ NUMBER OF CHILDREN_____

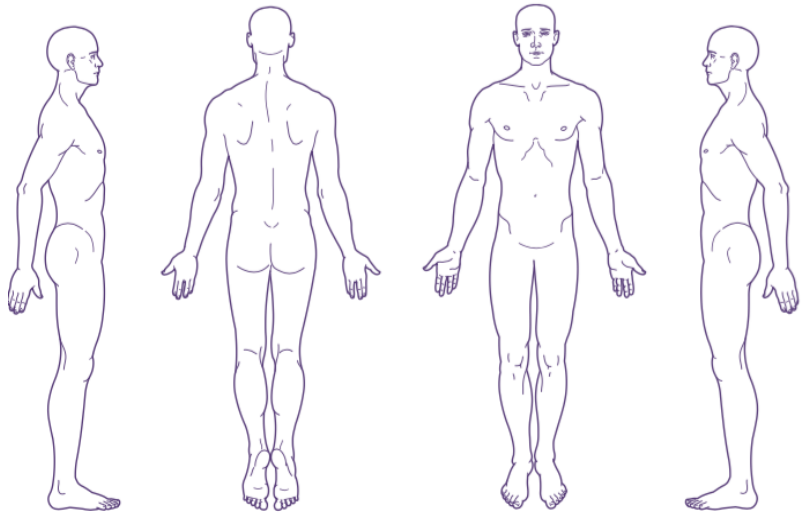
HOW DID YOU HEAR ABOUT OUR OFFICE?_____

CURRENT HEALTH CONCERNS:

1) CIRCLE AREAS OF PAIN OR CONCERN

2) RATE PAIN SEVERITY 1=VERY MILD, UP TO 10=UNBEARABLE
(PUT NUMBERS NEXT TO CIRCLES)

3) RATE FREQUENCY BY PLACING A LETTER NEXT TO EACH AREA:
(PUT LETTERS NEXT TO NUMBERS)
- O=OCCASIONAL
- F=FREQUENT
- V=VERY FREQUENT
- C=CONSTANT



LIST ANY ACTIVITIES THAT AGGRAVATE YOUR SYMPTOMS:

_____
_____
_____
_____

WHEN DID YOUR PRIMARY SYMTOM BEGIN?_____ HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST? Y____ N____

HOW IS IT PROGRESSING? GETTING WORSE_____ GETTING BETTER_____ STAYING THE SAME_____ COMES AND GOES_____

HAVE YOU TRIED ANY TREATMENT FOR THIS CONDITION? Y____ N____ IF YES, WHAT_____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? Y____ N____ IF YES, HOW LONG AGO?_____

SURGERIES, AUTO ACCIDENTS, OTHER INJURIES AND APPROXIMATE DATES: _____

_____

DO YOU EXPERIENCE: ____HEADACHES ____SINUS TROUBLE ___DIZZINESS ____RINGING EARS ____CONSTIPATION

ANYTHING ELSE YOU WANT THE DOCTOR TO KNOW? _____

_____

_____

SIGNATURE_____ Date_____