

WELCOME to the Florence Chiropractic and Wellness Center.

Thank you for choosing our practice for your chiropractic and wellness needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name: _____ Date: _____
First Middle Last

Prefer to be addressed as: _____

Social Security No.: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: _____

Preferred Phone Contact: Home Mobile

Email Address: _____

Gender: Male Female

Marital Status: Married Single Divorced Widowed Other

Cell Phone: _____

May we text you for office purposes? Yes

May we send you email notifications? Yes

Age: _____ Date of birth: _____

Occupation: _____

Emergency Contact: _____

Employer: _____

Phone Number: _____

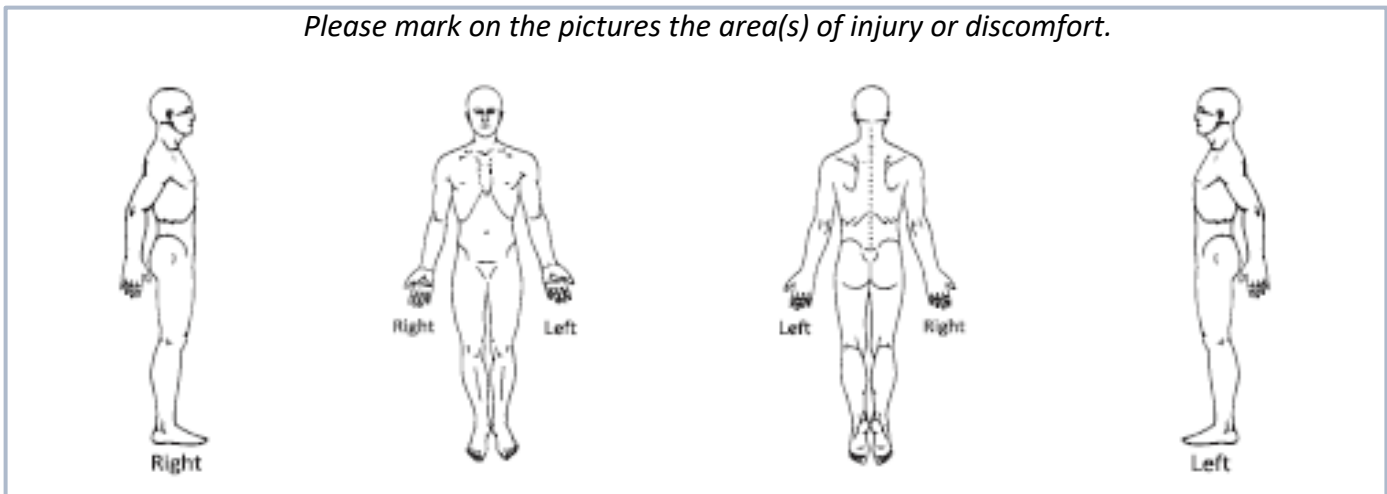
Whom may we thank for referring you to us? _____

Account Category:	<input type="checkbox"/> Self-Pay	<input type="checkbox"/> Workman's Compensation	<input type="checkbox"/> Health Insurance
	<input type="checkbox"/> Medicare	<input type="checkbox"/> Personal Injury / Auto	

Are you interested in:	<input type="checkbox"/> Chiropractic Treatment	<input type="checkbox"/> Nutrition Evaluation	<input type="checkbox"/> Both
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SHOW US WHERE YOU HURT

Please mark on the pictures the area(s) of injury or discomfort.



SYMPTOMS:

Reason for visit? _____
 Where is your problem located? _____
 When did it start? _____
 How did it start? _____
 Is this a reoccurring problem? _____ When? _____
 At what level has the pain been at its worst? Scale = 1 to 10 with 10 being the worst _____

Please check the character of your pain. *You may check more than one answer.*

<input type="checkbox"/> Sharp	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Shooting	<input type="checkbox"/> Achiness
<input type="checkbox"/> Dull	<input type="checkbox"/> Stiff	<input type="checkbox"/> Spasms	<input type="checkbox"/> Weakness	<input type="checkbox"/> Soreness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Pins and Needles			

How often are the complaints present?

Constant Frequent Intermittent Occasional

Is the pain?

Increasing Decreasing Staying the same

Pain is worsened by:

<input type="checkbox"/> Walking	<input type="checkbox"/> Sitting	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Changing from sitting to standing
<input type="checkbox"/> Standing	<input type="checkbox"/> Car Rides	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other _____

Pain is improved by:

<input type="checkbox"/> Rest	<input type="checkbox"/> Massage	<input type="checkbox"/> Prescription or Over the Counter Medication
<input type="checkbox"/> Heat	<input type="checkbox"/> Ice	<input type="checkbox"/> Exercise/Stretching/Moving

Is your pain restricting you from any activity? Describe: _____

Is there any dizziness associated with your condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any weight loss recently?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Explain _____
Do you currently have any fever or chills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your condition affecting your sleep?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Explain _____
Have you had any recent change in your bladder or bowel (bathroom) function?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

HISTORY:

What other treatment have you had for this complaint?

- | | | | |
|-------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Injections | <input type="checkbox"/> Surgery | <input type="checkbox"/> Family Doctor | <input type="checkbox"/> Over the counter medication |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Prescription Medication |

Who When and Where were these treatments received?

What medications are you currently taking?

_____	_____
_____	_____
_____	_____

What supplements (vitamins or herbs) are you taking?

_____	_____
_____	_____
_____	_____

Who is your Primary Care Physician (PCP)? _____

May I inform your primary physician or your referring physician of your treatment in my office?

- Yes No

Have you been treated by another chiropractor in the past

- Yes, No

If Yes, who was the Chiropractor and when were you last treated? _____

HISTORY:

Please check any current conditions.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bowel Disorders | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Cancer | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> COPD (breathing disorder) | <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Menstrual Difficulties | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis / Osteopenia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tingling in hands or feet | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vitamin Deficiencies | <input type="checkbox"/> OTHER _____ | |

Please describe any answers above:

List any prior surgeries:

List any prior accidents:

If you are female, are you pregnant? No Yes If Yes, what is your delivery date? _____
 Are you currently nursing? No Yes

FAMILY HISTORY:

Condition	Mother	Father	Siblings
Aneurysms	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Autoimmune Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

DAILY HABITS

Question			
What level of exercise you perform daily?	<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
What do your daily work habits include?	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking
	<input type="checkbox"/> Lifting to 10 Lbs.	<input type="checkbox"/> Lifting to 35 Lbs.	<input type="checkbox"/> Lifting greater than 50 Lbs.
How would you describe your current stress level?	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Do you typically sleep through the night?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
How many hours of sleep do you average nightly?	_____		
Do you currently smoke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, for how long? _____
Have you ever smoked?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, for how long? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, how many drinks per day? _____
Do you drink caffeine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, how many cups per day? _____

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Florence Chiropractic Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Florence Chiropractic Center. I understand that I am responsible for any payment not paid in full by my insurance carrier. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby request and authorize any doctor office, therapist, imaging center, or hospital, to furnish the Florence Chiropractic Center all records and reports they may request. I am allowing the Florence Chiropractic Center to perform reasonable and customary chiropractic treatments and/or nutritional recommendations as deemed helpful to my conditions.

Signature of Patient or parent if a minor. Date: _____

Signature of Witness Date: _____