Florence Chiropractic

PATIENT INFORMATION

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: _____ Cell Phone: _____
Preferred Phone Contact: ☐ Home ☐ Mobile
May we text you for office purposes? ☐ Yes
Email Address: _____
May we send you email notifications? ☐ Yes
Gender: ☐ Male ☐ Female
Age: _____ Date of birth: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Occupation: _____ Emergency Contact: _____
Employer Phone: _____ Phone Number: _____
Relationship: _____

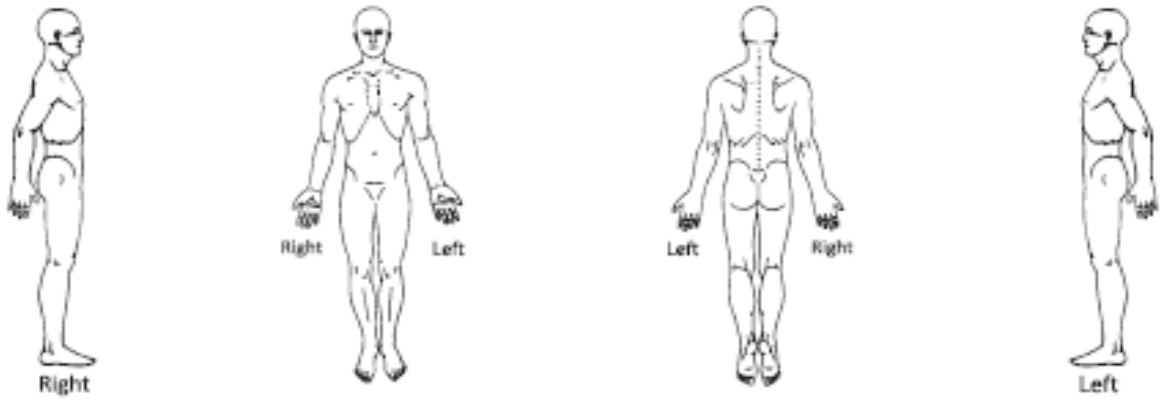
Whom may we thank for referring you to us? _____

Account Category:	☐ Self-Pay	☐ Workman's Compensation	☐ Health Insurance
	☐ Medicare	☐ Personal Injury / Auto	

Are you interested in:	☐ Chiropractic Treatment	☐ Nutrition Evaluation	☐ Both

SHOW US WHERE YOU HURT

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



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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.*

☐ Sharp ☐ Throbbing ☐ Burning ☐ Shooting ☐ Achiness
☐ Dull ☐ Stiff ☐ Spasms ☐ Weakness ☐ Soreness
☐ Numbness ☐ 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:

☐ Walking ☐ Sitting ☐ Sleeping ☐ Changing from sitting to standing
☐ Standing ☐ Car Rides ☐ Exercise ☐ Other _____

Pain is improved by:

☐ Rest ☐ Massage ☐ Prescription or Over the Counter Medication
☐ Heat ☐ Ice ☐ Exercise/Stretching/Moving

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

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

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HISTORY:

What other treatment have you had for this complaint?

☐ Injections ☐ Surgery ☐ Family Doctor ☐ Over the counter medication
☐ Massage ☐ Acupuncture ☐ Physical Therapy ☐ 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? _____

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HISTORY:

Please check any current conditions.

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

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	☐ Yes	☐ Yes	☐ Yes
Autoimmune Diseases	☐ Yes	☐ Yes	☐ Yes
Blood Clots	☐ Yes	☐ Yes	☐ Yes
Cancer	☐ Yes	☐ Yes	☐ Yes
Cholesterol	☐ Yes	☐ Yes	☐ Yes
Diabetes	☐ Yes	☐ Yes	☐ Yes
Heart Disease	☐ Yes	☐ Yes	☐ Yes
High Blood Pressure	☐ Yes	☐ Yes	☐ Yes
Osteoporosis	☐ Yes	☐ Yes	☐ Yes
Seizures	☐ Yes	☐ Yes	☐ Yes

DAILY HABITS

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

_____ Date: _____

Signature of Patient or parent if a minor.

_____ Date: _____

Signature of Witness