Ft. Caroline CHIROPRACTIC

Accident • Family Care • Wellness

Thank you for choosing Ft. Caroline Chiropractic Clinic for your chiropractic needs. Please complete this form in ink. If you have any questions, please do not hesitate to ask for assistance. We are happy to help.

Patient Information

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Preferred to be called (Nickname): _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

E-mail: _____

Preferred Contact Method: □ Phone □ e-Mail □ Text □ Postal Mail □ Other: _____

Sex: □ Female □ Male

Date of Birth: _____ SS#: _____

# of children: _____ Ages: _____

Preferred Language: _____ Race: _____

Ethnicity: □Non– Hispanic or Latino □ Hispanic or Latino □ Decline

□ Single □ Married □ Separated □Divorced □ Widowed □ Partnered □ Minor

Patient Employer/ School: _____ Occupation: _____

Spouse's or Parent's Name: _____ Employer: _____

Person to contact in case of emergency: _____ Phone: (___) _____

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (___)_____

Address: _____ City: _____ State: ____ Zip: _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insurance Company: _____ ID# : _____

Subscriber's Name (if different from patient): _____DOB: _____

How much is your deductible? _____ How much have you used? _____

What is your co-pay? _____

Do you have any additional insurance? □ Yes □ No **If YES, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Insurance Company: _____ ID# : _____

Subscriber's Name (if different from patient): _____DOB: _____

How much is your deductible? _____ How much have you used? _____

Accident Information

Is this condition due to an accident? □ Yes □ No Date of accident:_____

Type of accident: □ Auto □Work □Home □ Other _____

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Workman's Comp □ Other _____

Claim #: _____

If other person was at fault, please list their name, insurance company and claim #:

_____

_____

_____

Attorney Name (If applicable) : _____Phone: (___)_____

Symptoms

Reason for visit: _____ When did you first notice the symptom(s)_____

Is the condition getting progressively worse? _____

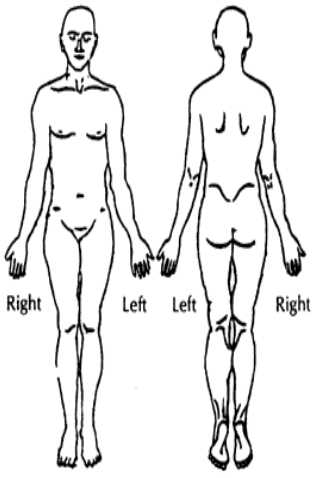
Mark an X where you have pain, numbness or tingling.

Rate the severity of your pain: (1= least to 10 = severe pain)

_____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching

□ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling



How often do you have this pain? _____

Is this pain constant or does it come and go? _____

Does it interfere with any of the following?

□ Work □ Sleep □ Daily Routine □ Recreation

Activities that are painful to perform?

□ Sitting □ Standing □ Walking □Bending □ Lying Down

What treatment have you received for your condition?

□ Medication □ Surgery □ Physical Therapy

□Chiropractic □ None □ Other _____

Name and address of other doctor(s) who have treated you for this condition:

_____

Any other information about your condition? _____

_____

Please list any other problems/complaints other than listed above: _____

_____

_____

_____

Health History (check only those conditions which apply)

□ AIDS/HIV	□ Cataracts	□ Heart Disease	□ Mumps	□ Sciatic Pain
□ Alcoholism	□ Chemical Dependency	□ Hepatitis	□ Osteoporosis	□ Stroke
□ Allergies	□ Chicken Pox	□ Hernia	□ Pacemaker	□ Suicide Attempt
□ Anemia	□ Depression	□ Herniated Disc	□ Parkinson's Disease	□ Thyroid Problems
□ Anorexia	□ Diabetes	□ Herpes	□ Pinched Nerve	□ Tonsillitis
□ Appendicitis	□ Dizzy Spells	□ High Cholesterol	□ Pneumonia	□ Tuberculosis
□ Arthritis	□ Emphysema	□ Kidney Disease	□ Polio	□ Tumors/ Growths
□ Asthma	□ Epilepsy	□ Liver Disease	□ Prostrate Problems	□ Typhoid Fever
□ Bleeding disorders	□ Fractures	□ Measles	□ Psychiatric Care	□ Ulcers
□ Breast Lump	□ Glaucoma	□ Migraines	□ Prosthesis	□ Vaginal Infections
□ Bronchitis	□ Goiter	□ Miscarriage	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bulimia	□ Gonorrhea	□ Mononucleosis	□ Rheumatic Fever	□ Whooping Cough
□ Cancer	□ Gout	□ MS	□ Scarlet Fever	□ Other _____

Date of last:
Physical Exam _____ Spinal X-Ray _____ Ct/MRI/Bone Scan _____

Please list Allergies: _____
_____

Please list vitamins and supplements you are taking: _____
_____
_____

Injuries/ Surgeries:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Auto Accidents	_____	_____
Surgeries	_____	_____

Family History

Relationship (age)	**Condition(s)**	**Alive (age)**	**Deceased**
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling(s)	_____	_____	_____

Medications

Medication Name	Dose	Form	Route	Frequency	Date Started
(i.e.. Zyrtec	*10 mg*	*Tablet*	*by mouth*	*once per day*	*10/24/2008)*

Medication Allergies (check only those allergies which apply)

□ ACE Inhibitors	□ Codeine	□ Keflex	□ Opiod Analgesics	□ Sertaline Derivitives
□ Amoxicillin	□ Darvon	□ Levaquin	□ Peroxitine Derivatives	□ Sulfa
□ Aspirin	□ Demorol	□ Lipitor	□ Paxil	□ Tetracycline
□ Bactrim	□ Erythromycin	□ Lisinopril	□ Penicillin	□ Ultram
□ Benadryl	□ Flagyl	□ Macrolides	□ Percoset	□ Zestril
□ Biaxin	□ HMG– COA Reductase	□ Mepridine	□ Pravachol	□ Zocor
□ Cefaclor	Inhibitors	□ Metronidazole	□ Propoxyphene	□ Zoloft
□ Cephalosporins	□ Ibuprofen	□ Morphine	□ Quinolones	□ Other _____
□ Cipro	□ Iodine	□ NSAIDS	□ Salicylates	□ Other _____

What are the reactions you face? (i.e.—Hives, Rash, etc…) _____

_____

Daily Habits

Exercise: □ Yes □ No Type: _____ Frequency: _____

Work Activity:	Sitting	□ Yes	□ No	Hrs/Day _____
	Standing	□ Yes	□ No	Hrs/Day _____
	Light Labor	□ Yes	□ No	Hrs/Day _____
	Heavy Labor	□ Yes	□ No	Hrs/Day _____
	Computer	□ Yes	□ No	Hrs/Day _____
	Driving	□ Yes	□ No	Hrs/Day _____

Other (describe): _____

Personal Habits:

Tobacco □ Yes □ No Packs/Week _____ Alcohol □ Yes □ No Drinks/Week _____

Caffeine □ Yes □ No Packs/Week _____ Water Intake □ Yes □ No Cups/Day _____

High Stress □ Yes □ No Reason: _____

How many hours of sleep do you get each night? _____

Do you sleep on: □ Side □ Back □ Stomach

How old is your pillow? _____ How old is your bed? _____

X-Ray Consent:

When medically necessary we may perform an X-Ray to help in diagnosing your condition. By signing below you confirm that you have had all of your questions regarding the necessity of an X-Ray answered and give consent to having X-Ray(s) taken. **If you are female, you are confirming that there is no possibility of you being pregnant by signing below.**

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Ft. Caroline Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Ft. Caroline Chiropractic Clinic may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient