Confidential Patient Data

PATIENT INFORMATION **Today's Date:**_____

Name:_____ Date of Birth:_____

Address:_____ City, State, & Zip_____

Email Address:_____ Reminders: □ Phone □ Email □ Both

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Gender: □Male □Female Age:_____

Marital Status: □Married □Single □Divorced □Separated □Other_____

Ethnicity: □Not Hispanic or Latino □Hispanic or Latino

Race: (Please check one): □White □Black/African American □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Other Race □More than one race □Unknown

Preferred Language (Please check one): □English □Spanish □French □German □Italian □Russian □Portuguese □Chinese □Japanese □Korean □Vietnamese

Social Security #:_____ Your Occupation:_____

Name of Your Employer:_____ Phone #:_____

Name of Emergency Contact:_____ Phone #:_____

Payment for services will be by: (You may check more than one.)
□Cash □Check □Credit/Debit Card □Health Ins. □Auto Ins. □Worker's Comp.

Name of Ins. Co.:_____ Insured's Date of Birth:_____

Insured's Employer:_____ Employer's Phone #:_____

Insured's Social Security #:_____ (If same as above, mark "SAME")

Are you covered by more than one insurance company? □Yes □No Name:_____

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = FATHER**

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes.)

S	M	F		S	M	F		S	M	F	
□	□	□	AIDS	□	□	□	dislocated joints	□	□	□	neck pain
□	□	□	anemia	□	□	□	epilepsy	□	□	□	nervousness
□	□	□	arthritis	□	□	□	German measles	□	□	□	numbness
□	□	□	asthma	□	□	□	headaches	□	□	□	polio
□	□	□	back pain	□	□	□	heart trouble	□	□	□	poor circulation
□	□	□	bladder trouble	□	□	□	reproductive issue	□	□	□	hepatitis
□	□	□	bone fracture	□	□	□	high bld. pressure	□	□	□	rheumatic fever
□	□	□	cancer	□	□	□	HIV/ARC	□	□	□	rheumatism
□	□	□	chest pain	□	□	□	kidney disorder	□	□	□	scarlet fever
□	□	□	concussion	□	□	□	bowel control loss	□	□	□	serious injury
□	□	□	convulsions	□	□	□	menstrual cramps	□	□	□	sinus trouble
□	□	□	diabetes	□	□	□	multiple sclerosis	□	□	□	tuberculosis
□	□	□	indigestion	□	□	□	muscular dystrophy	□	□	□	venereal disease

Have you ever received chiropractic care? □Yes □No If Yes, when?_____

Have you been treated by a physician for any health condition in the last year? □Yes □No

Describe Condition:_____ Date of Last Physical Exam:_____

Surgical History: (Please list type & date)

1._____ 2._____

3._____ 4._____

Have you ever had a metal implant? □Yes □No Have you ever been gunshot? □Yes □No

Accident History:

1. □Job □Auto □Slip & Fall □Other_____ Date:_____
2. □Job □Auto □Slip & Fall □Other_____ Date:_____
3. □Job □Auto □Slip & Fall □Other_____ Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

(Please list your complaint & then rate your symptoms 1-10; with 1 being the least serious) (1 -10)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

When and how occurred?_____

_____

Symptoms are worse in: □Morning □Afternoon □Night □Other_____

Symptoms developed from: □Job Related Injury □Auto Accident □Illness □Unknown Cause

□Other Accident □Gradual Onset □Other_____ Date Occurred:_____

Symptoms have persisted for # _____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

Please check the quality of the pain: □Aching □Burning □Deep □Dull □Nagging □Sharp

□Shooting □Throbbing □Other_____

Symptoms/Complaints: □Come & Go □Are Constant □Other_____

Have you ever had this before? □Yes □No If Yes, when:_____

If you were to guess, what do you think is causing your complaint(s)?_____

_____

Do you have children? □Yes □No If Yes, how many?_____

How would you describe your diet? □Balanced □Fair □Poor □Excessive □Restricted □Other

Explain:_____

Please tell us about your exercise habits.

□0-1 days per week □2-4 days per week □5+ days per week What type?_____

List any recreational activities._____

Please describe your stress levels. □Low □Moderate □High □Other_____

Do you currently use either of the following? □Alcohol □Drugs If you checked either box, please describe how much and how often:_____

Smoking Status: □Current *Every Day* Smoker □Current *Some Day* Smoker □*Former* Smoker □Never Smoked If you do smoke or did smoke, for how long?_____

Name & location of doctors previously seen for present condition:

1._____ 2._____

3._____ 4._____

Are you allergic to any medications? □Yes □No If Yes, what meds are you allergic to and what kind of reaction do you have to them?_____

_____

Are you taking any medications? □Yes □No If Yes, what are the medication names and dosages?

_____

_____

(FEMALES) Are you pregnant? □Yes □No Date of last menstrual period:_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *AGGRAVATE* YOUR CONDITION:

□bending □reaching □straining at stool □coughing □sitting □turning head □lifting □sneezing □walking □lying down □standing □other_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *RELIEVE* YOUR CONDITION:

□bending □sitting □lifting □standing □lying down □turning head □reaching □walking □other_____ □other_____

PLEASE CHECK ANY *ADDITIONAL SYMPTOMS* YOU MAY BE EXPERIENCING:

□blurred vision
□buzzing in ears
□cold feet
□cold hands
□cold sweats
□concentration loss/confusion
□constipation
□depression/ weeping spells
□dizziness
□diarrhea
□face flushed
□fainting
□fatigue
□fever
□head seems too heavy
□headaches
□light bothers eyes
□insomnia
□loss of balance
□loss of smell
□loss of taste
□low resistance to colds
□muscle jerking
□numbness in fingers
□numbness in toes
□pins & needles in arms
□pins & needles in legs
□ringing in ears
□shortness of breath
□stiff neck
□upset stomach

I have completed and understand the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Port Orange Chiropractic, Inc. staff to provide me with chiropractic care, in accordance with the state's statutes.

Patient's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

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Office Use Only
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Patient #:_____

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~ ~