

# CARE CHIROPRACTIC & WELLNESS CENTER

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## NEW PATIENT INFORMATION FORM

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Marital Status: \_\_\_ S \_\_\_ M \_\_\_ W \_\_\_ D SocSec# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

Describe health of spouse: \_\_\_\_\_ Number of children if any \_\_\_\_\_

**Whom may we thank for referring you:** \_\_\_\_\_

Is this your first visit to a Chiropractic Office? \_\_\_ Yes \_\_\_ No

Is this condition due to an accident? \_\_\_ Yes \_\_\_ No *(If yes, please ask receptionist for an accident data sheet.)*

Date of accident: \_\_\_\_\_ Type: \_\_\_ Auto \_\_\_ Work \_\_\_ Home \_\_\_ Other \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

What is your major complaint (reason you are here): \_\_\_\_\_

Previous treatments for this complaint: \_\_\_\_\_

Other complaints or problems: \_\_\_\_\_

Current medications/drugs being taken: \_\_\_\_\_

Current Nutritional Supplements: \_\_\_\_\_

# CARE CHIROPRACTIC & WELLNESS CENTER

## NEW PATIENT INFORMATION FORM-continued

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit): \_\_\_\_\_

### HISTORY:

List any surgery or operations with approx. dates: \_\_\_\_\_

Have you been in an auto or other accident: \_\_\_past year \_\_\_past five years \_\_\_over five years \_\_\_ Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders? \_\_\_Yes \_\_\_No When? \_\_\_\_\_

Have others in your family had such disorders? \_\_\_Yes \_\_\_No When? \_\_\_\_\_

Have you ever been knocked unconscious? \_\_\_Yes \_\_\_No Describe: \_\_\_\_\_

Have you ever had a fractured bone or dislocation? \_\_\_Yes \_\_\_No Describe: \_\_\_\_\_

Do you smoke, drink coffee, soda or alcohol? (If yes, indicate how much) Cigarettes \_\_\_\_\_ packs/day  
Coffee \_\_\_\_\_ cups/day Soda \_\_\_\_\_ cans or oz./day Alcohol \_\_\_\_\_ drinks/week

What is your current Stress Level? \_\_\_Low \_\_\_Medium \_\_\_High Reason: \_\_\_\_\_

How often do you exercise? \_\_\_ None \_\_\_ 1-2 times/week \_\_\_ 3-5 times/week \_\_\_ 6-7 times/week

Any household pets or other animals you or family members are in close contact with: \_\_\_\_\_

What can we do to make you happier? \_\_\_\_\_

I understand that all medical records are the property of CARE Chiropractic & Wellness Center and the original shall remain in their office as required by Florida law. Should I need copies of said records, an appropriate fee may be assessed for the cost of making such copies as provided by Board of Chiropractic Medicine Rule 64B2-17.0055.

I authorize CARE Chiropractic & Wellness Center to send me written correspondence, including their monthly health newsletter, by email when appropriate. I authorize my name to appear on the New Patient Referral Board if I refer a new patient to this office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

(Rev 05/06/05)

# Confidential Patient Case History

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms, which you currently have or have had in the past. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

## C-CURRENT P-PAST

C	P	GENERAL
<input type="checkbox"/>	<input type="checkbox"/>	Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep
<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/depression
<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
		<b>MUSCLE &amp; JOINT</b>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders
		Pain or numbness in:
<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Arms
<input type="checkbox"/>	<input type="checkbox"/>	Elbows
<input type="checkbox"/>	<input type="checkbox"/>	Hands
<input type="checkbox"/>	<input type="checkbox"/>	Hips
<input type="checkbox"/>	<input type="checkbox"/>	Legs
<input type="checkbox"/>	<input type="checkbox"/>	Knees
<input type="checkbox"/>	<input type="checkbox"/>	Feet
<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone
<input type="checkbox"/>	<input type="checkbox"/>	Poor posture
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature
<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints

C	P	GASTRO-INTESTINAL
<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion
<input type="checkbox"/>	<input type="checkbox"/>	Distension of abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood
		<b>EYES, EARS, NOSE &amp; THROAT</b>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Colds
<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	Ear noises
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	Far sightedness
<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction
<input type="checkbox"/>	<input type="checkbox"/>	Near sightedness
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis

C	P	CARDIO-VASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles
		<b>RESPIRATORY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood
<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
		<b>SKIN</b>
<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
		<b>GENITO-URINARY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Inability to control bladder
<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine
		<b>FOR WOMEN ONLY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts
<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache
<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?

## CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chorea	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Malaria	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping cough