4039 13th Street St. Cloud, FL 34769 Phone # 407-957-1337 Fax # 407-957-1848

Name:________________________________ Birthdate:____/____/____ Age:_____ ☐ Male ☐ Female

Address:___________________________________City:_________________ State:______ Zip: _________

Email:__________________________________ Mobile #: ____-_____-______ Home #: ______-______-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower Social Security # ______-______-______

Person to contact in case of an emergency : Name:_____________________ Phone #______-______-______

Occupation: ____

Primary Care Physician Name : __________________________Phone #_______-_______-_______

Pharmacy Name: _______________________________________ Phone #_______-_______-_______

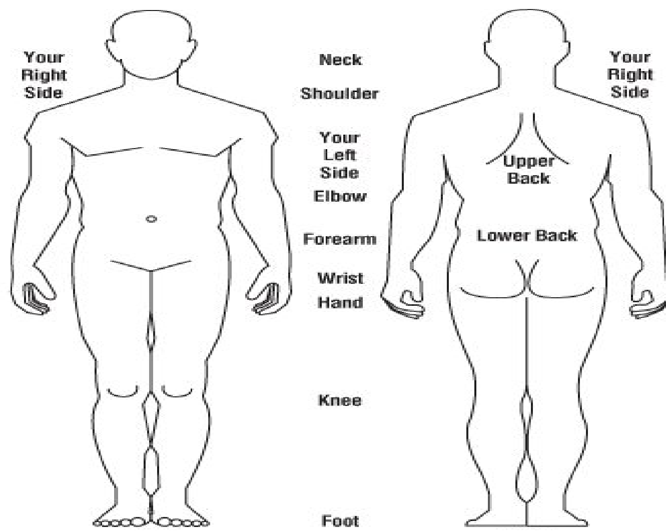
Tell us why are you here today:

☐ Chiropractic ☐ Acupuncture ☐ Massage Therapy ☐ Family Practice
☐ Regenerative Medicine ☐ Kinesiology

First Complaint: _____________________________________ 1-10 rate your pain_____
When did this problem first begin? ____
When is the problem worse? ☐ Morning ☐ Night ☐ Afternoon ☐ All day
Is this problem: ☐ Constant ☐ On and Off
What relieves your symptoms? ____
What makes your symptoms worse?____

Second Complaint: _____________________________________ 0-10 rate your pain_____
When did this problem first begin? ____
When is the problem worse? ☐ Morning ☐ Night ☐ Afternoon ☐ All day
Is this problem: ☐ Constant ☐ On and Off
What relieves your symptoms? ____
What makes your symptoms worse?____

Key: A=ACHE,
B=BURNING,
S=STABBING,
N=NUMBNESS,
P=PINS & NEEDLES,
O=OTHER



Patient History

1st box: You, 2nd box: Mother, 3rd box: Father

□□□ Anemia
□□□ Hyperlipidemia (High Cholesterol)
□□□ Hypertension (High BP)
□□□ Arthritis
□□□ Asthma
□□□ Kidney Disease
□□□ Liver Disease
□□□ Congestive Heart Failure
□□□ Migraine
□□□ COPD/Emphysema

□□□ Osteoporosis
□□□ Dementia
□□□ Parkinson's Disease
□□□ Depression/Anxiety
□□□ Pulmonary Embolism
□□□ Diabetes Mellitus
□□□ Reflux/GERD
□□□ Seizures/Epilepsy
□□□ Skin Disease
□□□ Blood Clot
□□□ Heart Attack (MI)
□□□ TIA/CVA (Stroke)
□□□ Thyroid Disease

□□□ Cancer
□□□ Allergic Rhinitis
□□□ Substance Abuse
□□□ Glaucoma
□□□ Broken bones
□□□ Dislocation
□□□ Other: _____________
____

Surgeries/Hospitalizations

□ Appendectomy
□ Coronary Artery Bypass (Open Heart)
□ Hysterectomy)
□ Nephrectomy
□ Carotid Endarterectomy

□Cholecystectomy (Gallbladder)
□ Splenectomy
□ Pacemaker/Defibrillator
□Tonsillectomy, Adenoidectomy

□Bariatric - (Gastric Bypass, Lap Banding
□ Other:________________
____

Accidents:

Auto accident: when? ______________________________ Slip & Fall: when?____________________

Did you receive treatment? Y/N When? ______________________ Where? ______________________

Please describe any other spinal trauma you have ever had?_________________________________

Do you, or have you ever participated in any of the following sports:

□ Football □ Wrestling □ Basketball □ Baseball □ Soccer □ Tennis □ Gulf □ Track and Field

Medications / Supplements

Name	**Dosage**	**How often**	**Reason for use**

Allergies

Name	Reaction

Social History

Do you use tobacco ☐ No ☐ Yes Former Smoker? ☐ No ☐ Yes

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ Weekends ☐ Socially

For Females Only:

Are you pregnant now? ▫ Yes ▫ No ▫ Unsure ▫ Actively trying
Indicate number of : Live births_____ Pregnancies_____ Miscarridges_____
Age: First Period _____ Menopause_____
Is your menstrual cycle regular? ▫ Yes ▫ No

Regarding X-rays and Imaging studies

☐ to the best of my knowledge, I am not currently pregnant.

By my signature below I am acknowledging that the doctor or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to X-rays. After careful consideration I therefore, do hereby consent to have the diagnostic X-ray examination performed which the doctor has deemed necessary in my case.

____

Patient or Parent/ Guardian's Signature Date: