Suncoast Chiropractic and Acupuncture, P.A.

P.O. Box 380236, Murdock FL 33938 • Phone: 941-743-9904 • Fax: 941-743-9905

Name_____ Sex M F Date_____

Email Address_____ Occupation_____

Address_____ City _____ State_____ Zip_____

H. Phone (_____)_____ Cell Phone_____ Date of Birth_____ Age_____

Referred by_____ Social Security #_____

Race_____ Ethnicity (circle one) Hispanic Non-Hispanic

Secondary Address_____ City _____ State_____ Zip_____

1. Primary reasons for seeking chiropractic care:

Chief complaint: _____

Complaint Began? _____ Did it begin gradually or suddenly? Is the Complaint: Worse Same Better ?

Did anything contribute to the onset? _____

Have you had this condition in the past? Yes - No Have you ever received Chiropractic Care? _____If yes, when? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain, 10=Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

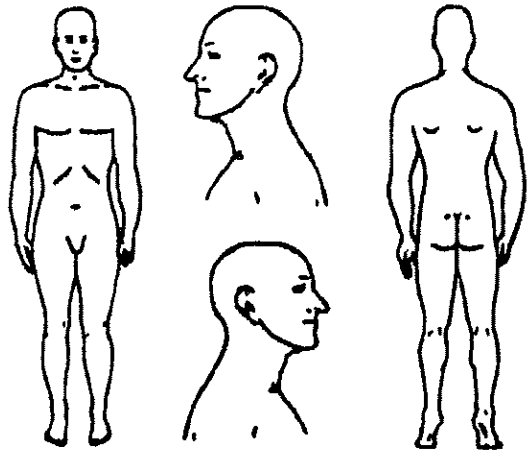
Does anything make the complaint better? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 0 1 2 3 4 5 6 7 8 9 10

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



A = Ache

B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other

M = Muscle Spasms

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Past Health History:

Please mark any of the following that you have now or have experienced:

Previous	Current		Previous	Current		Previous	Current	
		Hypertension			Diabetes			Depression
		Atherosclerosis			Tinnitus			Unexplained Weight Loss
		History of CVA			Migraines			Dizziness
		Heart Attack			Asthma			Speech or swallowing Problems
		Stroke			Allergies			Blurred Vision
		Cancer			Vertigo			Headaches

Allergies

Type:	**Location** (skin, local, abdominal, systematic/anaphylactic	**Reaction Symptoms**	**Approx. Start Date of Allergy**

Medications/Dosage

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

2Office Use Only: Height:_____" Weight:_____ BP:_____/_____ Pulse: _____ Initials: _____

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3. Previous injury or trauma

Have you ever been in a motor vehicle accident? No Yes When? _____

Were you injured? No Yes (describe): _____

Have you had any other personal injury or accident? No Yes (when?): _____

Describe: _____

Have you ever broken any bones? Which? _____

C. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

D. Females:

What was the date of the beginning of your last menstrual period? _____

2. Family Health History:

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Deaths in immediate family: Cause of parents or siblings death — Age at death

_____ _____

_____ _____

3. Social and Occupational History:

A. Marital Status: _____

B. Education Level: O high school O some college O college graduate O post graduate studies

C. Job description: _____

D. Work schedule: _____

E. Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use:

Do you drink alcohol? No Yes - if yes how many per day? _____

Do you smoke? No Yes – if yes how many packs per day? ____ For how long? ____

Previous Smoker? Yes No

Do you drink caffeine? No Yes – if yes how many per day? _____

Do you exercise? No Yes if yes (what forms and how often): _____

3Office Use Only: Height:_____" Weight:_____ BP:_____/_____ Pulse: _____ Initials: _____

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I have read the above information and certify it to be true and correct to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic and Acupuncture care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I request that payment of authorized Medicare benefits be made on my behalf to Suncoast Chiropractic and Acupuncture, PA for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits for related services.

I hereby assign any and all legal rights required with respect to the enforcement of medical benefit provisions of any insurance policy under which I qualify for benefits, including the right to proceed in AAA arbitration, necessary to collect monies due and owing to Suncoast Chiropractic for medical services which were provided to me. This is a limited assignment of rights solely for the purpose of collecting fees for outstanding medical services by the named provider. I specifically do not assign and thereby reserve all other rights and obligations, including the duty to co-operate with the insurance company, with respect to the enforcement of all other medical benefits coverage.

Patient or Guardian Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be places in my patient chart and maintained for six years.

_____ _____

Patient Name (Please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

4Office Use Only: Height:_____" Weight:_____ BP:_____/_____ Pulse: _____ Initials: _____