Dr. Craig J. Benton

Suncoast Chiropractic and Acupuncture, P.A.
Suncoast Wellness Club
687 Tamiami Trail ● Port Charlotte, FL 33953 ● (941)743-9904

Name_____ Date_____

Address_____ State_____ Zip_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Gender: ◯ Female ◯ Male Social Security # _____ ____ _____

Height: ☐ Feet ☐ Inches Weight: _____lbs.

Email: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____

Address_____ State_____ Zip_____

Are you employed? ◯ Yes ◯ No ◯ Retired

Are you on disability? ◯ Yes ◯ No Reason: _____

Workman's Compensation? ◯ Yes ◯ No Reason: _____

Seeking treatment for a motor vehicle accident? ◯ Yes ◯ No

Referred by: _____

Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Location of Complaint: _____

Complaint Began when _____and how? _____

_____

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 (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 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? _____

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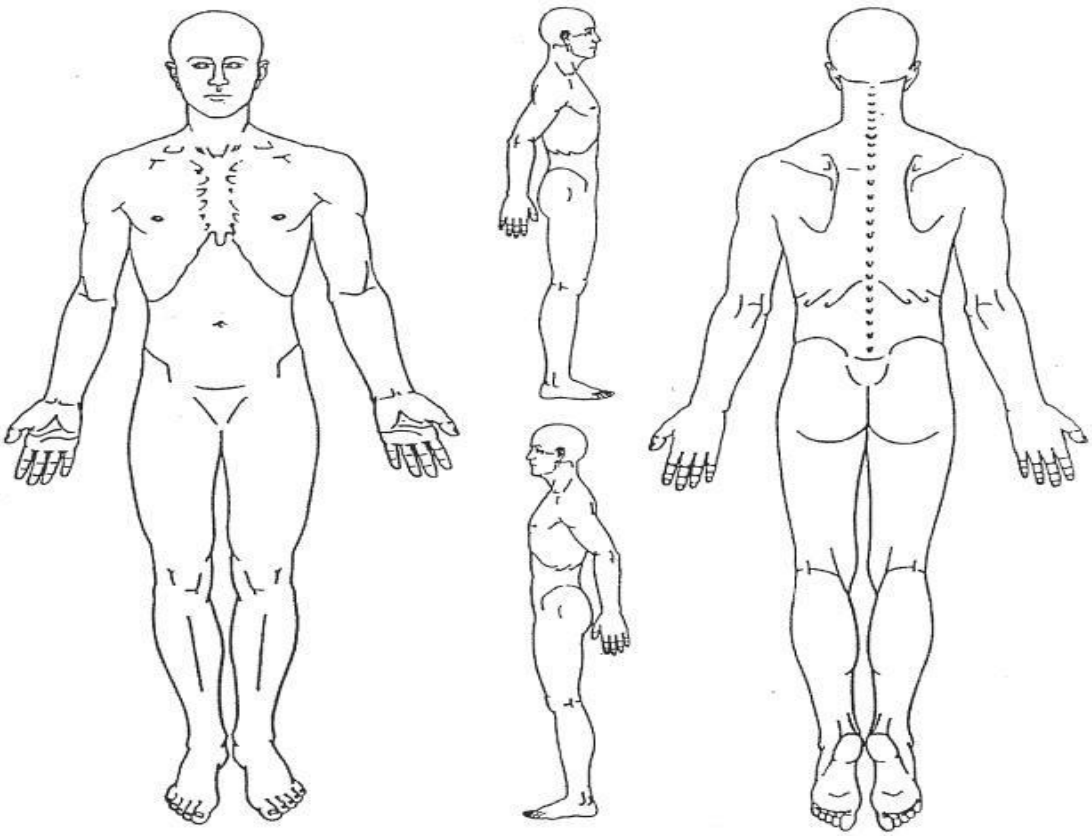
On the diagram below, please indicate where you are experiencing pain, right now. please complete both sides of this form.



A = ACHE
O = OTHER

B = BURNING
S = STABBING

N = NUMBNESS
P = PINS & NEEDLES

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Treatment History:

Treatment	Yes	No	Helpful/Complications	Comments
Pain Management				
Physical Therapy				
Surgery				
Chiropractic				
Acupuncture				
Massage				
Other:				

Diagnostic Studies: (Related to today's visit)

Test	Yes	No	Date (if known)	Where/Findings
X-ray				
MRI				
CT-scan				
Other:				

Medications:

Medication:	Why are you taking:

Allergies: _____

Social History:

Do you smoke? ◯ Yes ◯ No If yes, How many a day?_____ How long?_____

Do you drink alcohol? ◯ Yes ◯ No If yes, How frequent? _____ What type? _____

Do you have a history of drug or alcohol addiction? ◯ Yes ◯ No

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Other:_____

Recreational activities: _____

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Medical History:

In the last 3 months: (circle yes or no)

Yes	No	Heart attack	Yes	No	Diabetes
Yes	No	Angina	Yes	No	Thyroid problems
Yes	No	Irregular heart beat	Yes	No	Kidney disease
Yes	No	Heart murmur	Yes	No	Liver disease
Yes	No	High blood pressure	Yes	No	Cancer
Yes	No	Low blood pressure	Yes	No	Gallbladder problems
Yes	No	COPD	Yes	No	Arthritis
Yes	No	Asthma	Yes	No	Disc disorders (disc bulge, degenerative)
Yes	No	Stroke	Yes	No	Anti-coagulant therapy (blood thinner)
Yes	No	Headache	Yes	No	Visited hospital

Surgical History:

Type of Surgery:	Date

Injury or Traumatic History:

Have you ever been in a motor vehicle accident? ◯ Yes ◯ No If yes when?_____

If yes, injured? ◯ Yes ◯ No If yes, describe: _____

Have you had any other injuries or accidents? ◯ Yes ◯ No If yes, when and describe: _____

_____

Have you broken any bones? ◯ Yes ◯ No If yes, which? _____

Family History:

Relative	Age	Heart Disease	Cancer	T.B.	Diabetes	Age at death	Cause of death
Father		Yes No	Yes No	Yes No	Yes No		
Mother		Yes No	Yes No	Yes No	Yes No		
Sister(s)		Yes No	Yes No	Yes No	Yes No		
Brother(s)		Yes No	Yes No	Yes No	Yes No		

OFFICE USE ONLY:

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____ Initials: _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, acupuncture, and traction on me (or on the patient named below for which I am legally responsible) by the licensed doctor of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Printed name of patient

_____ _____
Signature of Patient Date

_____ _____
Signature of patient's representative (if minor) Date

_____ _____
Signature of Witness Date

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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 placed in my patient chart and maintained for six years.

By checking the boxes below, I authorize being contacted for practice reminders or promotions by:

Mail □ at this address: _____

Email□ at email address _____

Telephone □ at the following numbers: _____

By voice mail: □By text message: □ at the following number: _____

By checking this box below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. □

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____