ABOUT THE PATIENT

Functional Spine & Wellness, Coral Springs, FL 33065

Name _____ Date of Birth _____ Age _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

E-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Name of Medical Doctor(s)_____

- I authorize the doctor or her staff to render care as deemed appropriate for me and / or my child.
- I authorize Alter Chiropractic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

LIST AREAS OF CONCERN:

Complaint #1 _____ When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes Pain radiates (travels) to: _____

What makes it better? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

What makes it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

Treatments you have already had for this? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ _____

Complaint #2 _____ When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes Pain radiates (travels) to: _____

What makes it better? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

What makes it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

Treatments you have already had for this? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ _____

Complaint #3 _____

When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing

Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes

Pain radiates (travels) to: _____

What makes it better? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

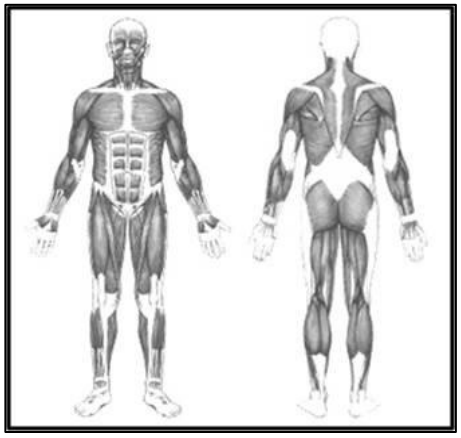
What makes it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

Treatments you have already had for this?

❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ _____

Are you pregnant?
❑ Yes ❑ No

Please mark ALL areas of concern



GENERAL HEALTH HISTORY

Functional Spine & Wellness, Coral Springs, FL 33065

Patient Name_____

Mark only the conditions that apply to you:

Past	Present		Past	Present	
			❑	❑	Kidney Disease
❑	❑	Anemia	❑	❑	Liver Disease
❑	❑	Arthritis	❑	❑	Migraines / Headaches
❑	❑	Asthma	❑	❑	Multiple Sclerosis
❑	❑	Breast Lump	❑	❑	Osteoporosis
❑	❑	Cancer	❑	❑	Pacemaker
❑	❑	Diabetes	❑	❑	Parkinson's disease
❑	❑	Emphysema	❑	❑	Pinched Nerve
❑	❑	Epilepsy	❑	❑	Prostate Problem
❑	❑	Gout	❑	❑	Prosthesis
❑	❑	Heart Disease	❑	❑	Rheumatoid Arthritis
❑	❑	Hepatitis	❑	❑	Stroke
❑	❑	Hernia	❑	❑	Thyroid
❑	❑	Herniated Disc	❑	❑	Other: _____
❑	❑	High Cholesterol	❑	❑	Other: _____

EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy ❑ Cardio ❑ Weights ❑ Other _____

WORK ACTIVITY: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

STRESS LEVEL: ❑ Low ❑ Average ❑ High ❑ Very High **Why**: _____

HABITS: ❑ Smoking ___ Packs / day ❑ Alcohol ___ Drinks / week ❑ Caffeine ___ Cups / Day

PAST HISTORY

Injuries / Surgeries you have had **Description / Approximate Date**

Falls: _____

Broken Bones: _____

Surgeries: _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No Date: _____

Type of Accident: □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Worker Comp □ Other