CAPE CORAL FAMILY CHIROPRACTIC, P.L.

210 DEL PRADO BLVD SOUTH, SUITE 3, CAPE CORAL, FL 33990

PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex □ Male □ Female Age _____

Birthdate _____

□ Married □ Widowed □ Single

□ Separated □ Divorced □ Minor

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Subscriber's Name _____

Employer's Name _____

Relationship to Patient _____

Insurance Co. _____

Claim # _____

Group # _____

ID # _____

Adjuster's Name _____

Phone # _____

Attorney's Name _____

Phone # _____

Address _____

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Drivers License # _____

ACCIDENT INFORMATION

Is condition due to an accident? □ Yes □ No

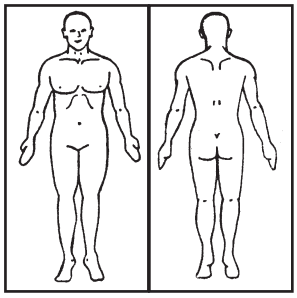
Date _____

Type of accident □ Auto □ Work □ Home □ Other

To whom have your made a report of your accident?

□ Auto insurance □ Employer □ Workers Comp. □ Other

PATIENT CONDITION



Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? □ Yes □ No

Mark and X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (lease pain) to 10 (severe pain) _____

Type of pain □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Welling □ Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform □ Sitting □ Standing □ Walking □ Bending □ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? □ Medications □Surgery □ Physical Therapy
□ Chiropractic Services □ None □ Other _____

Names and addresses of other doctor(s) who have treated you for your condition

_____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
MRI _____ CT Scan _____ Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Depression	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Anemia	□ Yes □ No	Emphysema	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Anorexia	□ Yes □ No	Epilepsy	□ Yes □ No	Migraine Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Appendicitis	□ Yes □ No	Erectile Dysfunction	□ Yes □ No	Miscarriage	□ Yes □ No	Sleeplessness	□ Yes □ No
Asthma	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Tonsillitis	□ Yes □ No
Breast Lump	□ Yes □ No	Gout	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bronchitis	□ Yes □ No	Heart Disease	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors, Growths	□ Yes □ No
Bulimia	□ Yes □ No	Hepatitis	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Typhoid ever	□ Yes □ No
Cancer	□ Yes □ No	Hernia	□ Yes □ No	Pinched Nerve	□ Yes □ No	Ulcers	□ Yes □ No
Cataracts	□ Yes □ No	Herniated Disk	□ Yes □ No	Pneumonia	□ Yes □ No	Venereal Disease	□ Yes □ No
Chemical		Herpes	□ Yes □ No	Polio	□ Yes □ No	Whooping Cough	□ Yes □ No
Dependency	□ Yes □ No	High Blood Pressure	□ Yes □ No	Prostate Problem	□ Yes □ No	Other _____	
Chicken Pox	□ Yes □ No	High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	_____	

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□Smoking Packs/Day _____
□ Alcohol Drinks/Week _____
□ Coffee/Caffeine Drinks Cups/Day _____
□ High Stress Level Reason _____

Are you pregnant? □ Yes □ No Due Date _____

INJURIES/SURGERIES YOU HAVE HAD	**DESCRIPTION**	**DATE**
Falls		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**

Family Physician Name _____ Physician's Phone # _____ May we contact? □ Yes □ No

Patient Name: _____

FAMILY HISTORY	
□ Arthritis	□ Asthma
□ Back Pain	□ Cancer
□ Depression	□ Diabetes
□ Epilepsy	□ Genetic Spinal Condition
□ High Blood Pressure	□ Heart Problems
□ Multiple Sclerosis	□ Neurological Problems
□ Parkinson's	□ Polio
□ Prostate Problems	□ Stroke/Heart Attack
Other	

OFFICE POLICY

I understand that fees are payable at time of services unless other arrangements are made in advance. I am responsible for my full co-payment and/or deductible on each visit. I understand that x-rays are the property of the clinic: however, I may borrow the films and receive reports. I understand that when I terminate care that all fees are immediately due and payable unless other arrangements are made in writing. I authorize this office to furnish requested information to my insurer or attorney with a properly signed release.

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself, furthermore I understand that this Chiropractic Office will prepare any necessary reports to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

ASSIGNMENT OF BENEFITS

I hereby authorize Cape Coral Family Chiropractic Center PL to release my information necessary to process this claim and ASSIGN ALL BENEFITS payable directly to Cape Coral Family Chiropractic. I waiver the Statute of Limitations regarding my doctor's right to recover. I understand that whatever amount not collected from insurance proceeds I personally owe Cape Coral Family Chiropractic Center. If collection or legal actions should become necessary in payment of services rendered by Cape Coral Family Chiropractic Center I understand that I will be personally responsible for all fees incurred by said office.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he may designate as his assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that the doctor deems necessary in my case; and I further authorize him to disclose all or any part of my (patient) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient of to a family member or employer of the patent for all or part of the clinic's charge, including and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patients employer.

Patient Signature: _____

Consent to treat and exam a minor: I authorize Cape Coral Family Chiropractic Clinic Physicians and whomever they designate as assistants to examine, x-ray and administer appropriate care as they deem necessary to my under age child.

Patient or Guardians signature: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: Date _____

We need this confidential information answered completely to help us assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient.

Thank You.

GENERAL INFORMATION:

Name_____Sex___MaritalStatus___DateofBirth_____HomePhone( )_____

Address _____ City _____ State _____ Zip _____

Occupation _____ Work Phone ( ) _____ OK to call there? ____

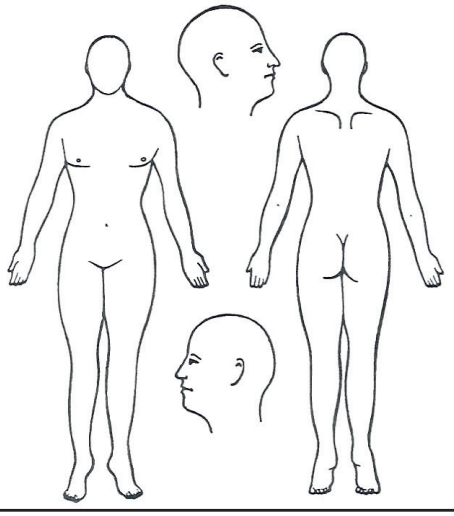
NATURE OF ACCIDENT:

1. What was the time and date of this present injury? _____ AM _____ PM _____ 20 _____
2. Please explain in detail how your accident happened. _____
   _____
   _____
3. Were you: _____ driver _____ passenger _____ front seat _____ back seat
4. What direction were you headed? _____ North _____ East _____ South _____ West
5. What direction was the other vehicle headed? _____ North _____ East _____ South _____ West
6. Were you struck from: _____ behind _____ front _____ left side _____ right side
7. How many cars were involved in the accident? _____
8. Were you wearing a seat belt? _____ Other protective devices? _____
9. Did you come in contact with any objects in the car? _____ If yes, what objects (i.e. windshield, steering wheel, door frame)? _____
10. What parts of your body came in contact with the above object(s)? _____
    _____
11. Were you unconscious as a result of the injury? _____ If yes, how long?
    _____
12. Were you bleeding as a result of the injury? _____
13. Where did you feel pain or unusual feeling immediately after the accident? (Please show the areas on the diagram also.) _____
    _____
14. Were the police notified? _____
15. Where were you taken after the accident? _____
    _____
16. What treatment did you receive? _____
    _____
    _____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING IMMEDIATELY AFTER ACCIDENT.

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
xxxxxxxxxx	.....	(xxxxxxxx)	wwwwwwwww	IIIIIIIII
xxxxxxxxxx	.....	(xxxxxxxx)	wwwwwwwww	IIIIIIIII
xxxxxxxxxx	.....	(xxxxxxxx)	wwwwwwwww	IIIIIIIII



17. Was any other doctor consulted after your accident? _____
    If yes, what was the doctor's name _____ __DC __MD __DO __DDS
18. Describe the doctor's diagnosis? _____
19. What treatment did you receive? _____
20. Are you still under a doctor's care? _____ If yes, please explain _____
    _____

PAST HISTORY:

1. Have you ever injured this area before? _____ If yes, when? _____
2. Have you been involved in any previous accidents-of any kind (personal injury, automobile accident or workers' compensation)? _____ If yes, please explain dates and details _____
    _____
    _____
3. Have you been treated previously by a chiropractor? _____ If yes, please explain _____
    _____
4. Have you enjoyed good health prior to this accident? _____ If no, please explain (i.e., illnesses or injuries.) _____
    _____

PRESENT INFORMATION/DISABILITY:

1. Have you returned to work? _____ If yes, date returned to work _____
2. Job description _____
3. Are your work activities restricted as a result of this accident? _____ If yes, please explain _____
    _____
4. Do you notice any activity restrictions as a· result of this injury? _____ If yes, please describe _____
    _____
5. Since this injury are your symptoms: improving _____, getting worse _____, or the same _____?
    Please explain _____

LEGAL REPRESENTATION:

1. Have you retained an attorney? _____ If yes, name and address _____
    _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____
Patient's Signature Date

_____ _____
Doctor's Signature (upon review) Date