

ABOUT THE PATIENT

153 Roberts Village Ct, Ste 1502, Fruit Cove, FL 32259

Name _____ Today's Date _____ Birthdate _____ Age _____
 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 _____ ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Impact 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? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

Patient / Parent Signature

(This represents a long term authorization for all occasions of service)

Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
2. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
3. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
4. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____

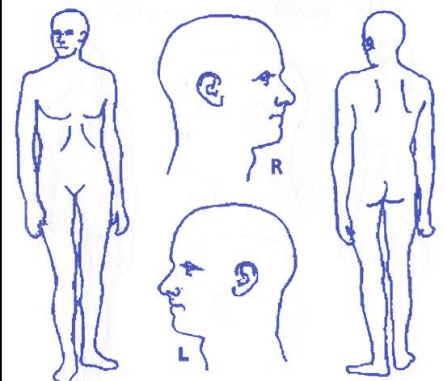
9. Type of treatment: _____

10. Results: _____

NOTES: _____

Are you pregnant?
☐ Yes ☐ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- ☐ Headaches
- ☐ Migraines
- ☐ Shortness of Breath
- ☐ Allergies / Asthma
- ☐ Medication Side Effects
- ☐ Diabetes
- ☐ Hands or Feet cold
- ☐ Muscle aches
- ☐ Trouble Walking
- ☐ Leg / Foot Numbness
- ☐ Fainting
- ☐ Gall Bladder Trouble
- ☐ Ringing in Ears
- ☐ Ear Problems
- ☐ Sleeping Problems
- ☐ Vision Problems
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Kidney Problems
- ☐ Light Bothers Eyes
- ☐ Other _____

Past Present

- ☐ Urinary Problems
- ☐ Easy Bruising
- ☐ Tobacco Use
- ☐ Dental Problems
- ☐ Fibromyalgia
- ☐ Blood Thinner use
- ☐ HIV Positive
- ☐ Cancer
- ☐ Depression
- ☐ Alcohol Use
- ☐ ___ High or ___ Low Blood Pressure
- ☐ Stroke History
- ☐ High Cholesterol
- ☐ TMJ
- ☐ Digestive Problems
- ☐ Pain all Over
- ☐ Tension / Irritability
- ☐ Chest Pains
- ☐ Heart Pacemaker
- ☐ Heart Problems

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ☐ No ☐ Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and 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? _____