

SEMINOLE CHIROPRACTIC INJURY AND WELLNESS CENTER

10863 PARK BLVD. #2 SEMINOLE, FL 33772
PHONE #727-399-2229 FAX #727-399-2228

NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, please fill out the personal information below. If you need assistance please inform the front desk person.

Personal Information:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Gender: M or F Marital Status: S M D W

Spouse Name: _____ Preferred Language: English / Other: _____

Date of Birth: ____ / ____ / ____ Age: _____

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

Home Email: _____ Work Email: _____

Preferred Method of Communication for Patient Reminders: (Circle One): Email / Phone / Mail

Emergency Contact: _____ Relationship: _____ Phone#: _____

CMS requires providers to report both race and ethnicity.

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American /
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Patient Signature: _____ Date: _____

**** For office use only ****

Height: _____ Weight: _____ Blood Pressure: _____ / _____

CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Location:

What is your Primary Complaint? _____

What Caused the Onset? _____

When did it Start? ____/____/____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

✓ Since the onset of your complaint how has it been changing? Getting Better Not Changing Getting Worse

✓ How often do you experience the complaint?

Constantly (100%) Frequently (75%) Occasionally (50%) Intermittently (25%)

✓ When does it feel worse? No Change Morning As day progresses Afternoon Evening During the night

✓ When does it feel better? No Change Morning As day progresses Afternoon Evening During the night

✓ How much has the complaint interfered with your normal work? (including both work and outside the home and housework)

Not at all A little bit Moderately Quite a bit Extremely

✓ How much would you say this complaint has affected your social activities?

All the time Most of the time Some of the time A little of the time None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe

7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating a

Please Circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

How would you describe the sensation of your complaint? (Circle all that apply)

Sharp Pain

Shooting

Numbness

Tingling

Dull Ache

Burning

Throbbing

Other _____

Modifying Factors:

What makes your complaint feel worse? (Circle all that apply)

Coughing / Sneezing

Standing

Lifting

Exercising

Bending

Twisting

Pushing / Pulling

Sitting

Walking

Driving

Climbing

Other: _____

Alleviating Factors:

What makes your complaint feel better? (Circle all that apply)

Rest / Sleep

Stretching

Lifting

Exercising

Bending

Twisting

Pain Medication

Ice

Heat

Shower

Walking

Other: _____

Previous Treatment:

Who have you seen for this condition?

Medical Doctor Physical Therapist Chiropractor Other: _____

Have you had Chiropractic care in the past? Yes No If so, When? ____/____/____

Are you seeing anyone else for other problems or health conditions? (Circle one) Yes / No

*Please list the problem/s, date problem/s began, and provider/s treating you for the condition/s: _____

Risk Factors:

Do you have a pace maker? Yes No Are you pregnant? Yes No Maybe

Do you have any metal implants or devices? Yes No

Patient / Guardian Signature: _____

Date: ____/____/____

Dr: _____

PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Please Make Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
x		<i>Example</i>	x	x	<i>Example</i>		x	<i>Example</i>
		Angina / Chest Pain			HIV			Seizures
		Arthritis			Hypertension			Sleeping Problems
		Asthma			Irritability			Soreness
		Back Pain			Joint Stiffness			Speaking Problems
		Balance Problems			Joint Swelling			Spinal Curvature
		Broken Bones			Joint Tenderness			Stiffness
		Cancer			Loss of Sleep			Stroke / TIA
		Chills			Lumps			Tingling
		Concentration Loss			Masses			Thyroid Problems
		Diabetes I / II			Memory Loss			Tremors
		Dizziness			Muscle Cramps			Vertigo
		Fatigue			Muscle Pain			Weakness
		Fainting			Nervousness			Other Please List:
		Fever			Night Sweats			
		Headaches			Numbness			
		Heat Problems			Paralysis			

Medication and Surgical History:

Are you currently taking any medications? (Please include regularly used over the counter medications, vitamins, herbs and minerals.) You may continue the medication information on the back if additional room is required.

Medication Name	Dosage and Frequency	Start Date of Medication

Do you have any allergies? (Circle all that apply): Food / Environment / Medication

Allergy	Reaction

*Please list any prior surgeries, major injuries or hospitalizations you may have had: _____

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient / Guardian Signature: _____

Date: / /

Dr: _____

SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

Social History:

- ✓ What is Your Current Work Status?
 Employed Full time Employed Part Time Retired Unemployed Disabled Student

- ✓ How Often Do You Exercise?
 Never 1-3 Times per month 1-2 Times per week 3-4 times per week Daily

- ✓ How Would You Rate the Intensity of Your Workout?
 Never Exercise Low Level Moderate Level High Level Competition Level

- ✓ How Many Hours Do You Sleep Per Night?
 <4 Hours 5-6 Hours 7-8 Hours 8-10 Hours >10 Hours

- ✓ How Often Do You Eat A Balanced Diet?
 Never Rarely Sometimes Regularly Always

- ✓ How Often Do You Drink A Caffeinated Beverage?
 Never 1-3 Times Per Month 1-2 Times Per Week 3-4 Times Per Week Daily >2 Per Day

- ✓ How Often Do You Smoke Cigarettes?
 Never Past 1-3 Packs Per Month 1-2 Packs Per Week 3-4 Packs Per Week >1 Pack A Day

- ✓ How Often Do You Drink Alcohol?
 Never Past 1-3 Drinks Per Month 1-2 Drinks Per Week 3-4 Drinks Per Week Daily

- ✓ Have You Used Illicit / Street Drugs In The Past 6 Months?
 Yes No

Daily Activities: So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies: _____

- ✓ Does Your Current Condition Affect Your Performance In These Activities Or Hobbies? Yes No

If So, How: _____

SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

Family History Information: Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:

***Arthritis:**

Yes No Whom: _____

***Back Pain:**

Yes No Whom: _____

***Cancer:**

Yes No Whom: _____

***Diabetes:**

Yes No Whom: _____

***Heart Disease:**

Yes No Whom: _____

***High Blood Pressure:**

Yes No Whom: _____

***High Cholesterol:**

Yes No Whom: _____

***Osteoporosis:**

Yes No Whom: _____

***Stroke:**

Yes No Whom: _____

***Thyroid Conditions:**

Yes No Whom: _____

Patient / Guardian Signature: _____

Date: _____ / _____ / _____

Dr: _____

Seminole Chiropractic, Injury & Wellness Center

- 1) How long can you walk before pain increases? _____ minutes
- 2) How long can you sit before pain increases? _____ minutes
- 3) How long can you stand before pain increases? _____ minutes
- 4) How long can you drive before pain increases? _____ minutes
- 5) How long can you exercise before pain increases? _____ minutes
- 6) How long can you sleep before pain increases? _____ minutes
- 7) Do you need assistance with dressing? Yes / No
- 8) Does your pain increase when standing from seated position? Yes / No
- 9) Does your pain increase when getting in and out of bed? Yes / No
- 10) What is the maximum weight you feel you could lift without pain increasing? _____ pounds
- 11) Does your pain increase going up and down stairs? Yes / No
- 12) What chores have been affected by pain? Please circle all that apply.
Cleaning Ironing Pet Care Gardening Laundry
Meal Prep/Cleanup Shopping Vacuuming
- 13) How far can you walk with no or minimal pain?
___ 0-50FT ___ 50-200FT ___ 200-500FT ___ 500+FT ___ ½ Mile+

Patient Name _____

Patient Signature _____

Date _____

SEMINOLE CHIROPRACTIC INJURY AND WELLNESS CENTER
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, diagnostic x-rays, physical therapy techniques, on me (or on the patient name below for which I am legally responsible).

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 strain 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 the 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.

There are times when individuals other than staff may see me receive treatments at the clinic or overhear discussions on my condition or insurance. I consent to others perceiving these interactions at the clinic, if additional privacy is required, I will inform the clinic staff. I have read of have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I 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