# Health and Wellness of Central Florida

## Patient Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

SSN/HIC/Patient ID#: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Birthdate: _____ Spouses SS#: _____

## Job/School Information

Occupation/School: _____ _____

Work/School Address: _____ _____

Work/School Phone: _____ _____

Whom may we thank for referring you? _____

## Emergency Contact Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

# CHIROPRACTIC REGISTRATION AND HISTORY

## INSURANCE INFORMATION

Who is responsible for this account?

Relationship to Patient:

Insurance Co.:

Group #:

Is patient covered by additional Insurance?

Subscriber's Name:

| Birthdate | SS #: |
|---|---|

Assignment And Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

*Name of Insurance company*

Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the befits payable for related services. This consent will end when my current treatment plan is compiled or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please Print Name of Patient, Parent, Guardian or Personal Representative

## ACCIDENT INFORMATION

| Is condition due to an accident? | If so, please provide date: |
|---|---|

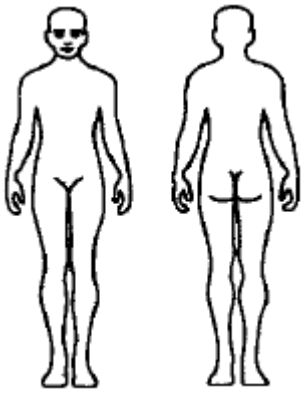
| Please Check type of accident: | Auto ☐ | Work ☐ | Home ☐ | Other ☐ |
|---|---|---|---|---|

| Who have you made a report of your accident to? | Auto Insurance:<br>Employer:<br>Workers Comp.:<br>Other: |
|---|---|

Attorney's Name (if applicable) :_____

## PATIENT CONDITION

Reason for Visit:

| | |
|---|---|
| When did your symptoms appear? | |
| Is this condition getting progressively worse? | |
| Mark an X on the picture where you continue to have pain, numbness, or tingling. |  |
| Rate the severity of your pain on a scale from 1(least pain) to10 (severe pain) | 1 2 3 4 5 6 7 8 9 10 |
| Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other | |
| How often do you have this pain? | |
| Is it constant 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 — Health and Wellness of Central Florida

What treatment have you already received for your condition? ___ Medications ___Surgery ___Physical Therapy
___Chiropractic Services ___None ___Other_____
Name and address 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_____
Dental x-ray_____ MRI, CT-Scan, Bone Scan_____

Please mark on "yes" or"no" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ___Yes | ___No | Fractures | ___Yes | ___No | Multiple Sclerosis | ___Yes | ___No | Stroke | ___Yes | ___No |
| Alcoholism | ___Yes | ___No | Glaucoma | ___Yes | ___No | Mumps | ___Yes | ___No | Suicide Attempt | ___Yes | ___No |
| Allergy Shots | ___Yes | ___No | Goiter | ___Yes | ___No | Osteoporosis | ___Yes | ___No | Thyroid Problems | ___Yes | ___No |
| Anemia | ___Yes | ___No | Gonorrhea | ___Yes | ___No | Pacemaker | ___Yes | ___No | Tonsillitis | ___Yes | ___No |
| Anorexia | ___Yes | ___No | Gout | ___Yes | ___No | Parkinson's Disease | ___Yes | ___No | Tuberculosis | ___Yes | ___No |
| Appendicitis | ___Yes | ___No | Heart Disease | ___Yes | ___No | Pinched Nerve | ___Yes | ___No | Tumors/ Growths | ___Yes | ___No |
| Arthritis | ___Yes | ___No | Hepatitis | ___Yes | ___No | Pneumonia | ___Yes | ___No | Typhoid Fever | ___Yes | ___No |
| Asthma | ___Yes | ___No | Hernia | ___Yes | ___No | Polio | ___Yes | ___No | Ulcers | ___Yes | ___No |
| Bleeding Disorder | ___Yes | ___No | Herniated Disc | ___Yes | ___No | Prostate Problems | ___Yes | ___No | Vaginal Infections | ___Yes | ___No |
| Breast Lump | ___Yes | ___No | Herpes | ___Yes | ___No | Prosthesis | ___Yes | ___No | Whooping Cough | ___Yes | ___No |
| Bronchitis | ___Yes | ___No | High Blood Pressure | ___Yes | ___No | Psychiatric Care | ___Yes | ___No | Other _____ | | |
| Bulimia | ___Yes | ___No | High Cholesterol | ___Yes | ___No | Rheumatoid Arthritis | ___Yes | ___No | _____ | | |
| Cancer | ___Yes | ___No | Kidney Disease | ___Yes | ___No | Rheumatic Fever | ___Yes | ___No | _____ | | |
| Cataracts | ___Yes | ___No | Liver Disease | ___Yes | ___No | Sexually Transmitted Disease | ___Yes | ___No | | | |
| Chemical Dependency | ___Yes | ___No | Measles | ___Yes | ___No | | | | | | |
| Chicken Pox | ___Yes | ___No | Migraine Headache | ___Yes | ___No | | | | | | |
| Diabetes | ___Yes | ___No | Miscarriage | ___Yes | ___No | | | | | | |
| Emphysema | ___Yes | ___No | Mononucleosis | ___Yes | ___No | | | | | | |
| Epilepsy | ___Yes | ___No | | | | | | | | | |

**EXERCISE**
____None
____Moderate
____Daily
____Heavy

**WORK ACTIVITY**
____Sitting
____Standing
____Light Labor
____Heavy Labor

**HABITS**
____Smoking
____Alcohol
____Coffee/Caffeine Drinks
____High Stress Level

Packs per day _____
Drinks per day_____
Cups per day_____
Reason_____

Are you pregnant? ____Yes ____No Due Date: _____

| **Injuries/Surgeries you have had** | **Description** | **Date** |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

**MEDICATIONS**

**Pharmacy Name:** _____

**Pharmacy Phone:** _____

**ALLERGIES**

**VITAMINS/HERBS/MINERALS**

# CAD INJURY HISTORY FORM

**General Information:**

Patient Name: _____
Today's Date: _____
Date of injury: _____

Marital Status: ___M ___S ___W ___D

Habits:

Smoke: None____ Pk/day____ Years____

Alcohol: ___Never ___Social ___Light ___Mod ___Heavy

Employment:

At time of crash: _____

Unemployed? ___Yes ___No

Due to crash? ___Yes ___No

Type of work: ___Office/Clerical ___Light labor ___Mod. Labor ___Heavy Labor

**Past Medical History:**

Surgeries (dates and residuals:) _____

Fractures (dates and residuals:)_____

Serious illness (dates and residuals:)_____

Worker's comp. injuries (date, TX, awards, residuals:)_____

Personal injuries (date, TX, awards, residuals:) _____

Sports or other injuries to head, neck or back: _____

Past medical history (cont'd)

Any prior HX of current complaints:

1. _____
2. _____
3. _____

Prior TX by DC for these injuries:

1. _____
2. _____
3. _____

Current medical history: _____

Current health problems: _____

Current Medications: _____

**Injury History General:**

Was the crash on-the-job: ___Yes ___No
You were the: ___Driver ___Front seat passenger
___Rear seat passenger ___Motorcycle operator
___Motorcycle passenger ___Other_____
Vehicle driven by: _____
Your Vehicle (year, make, model) _____
Your estimated speed at the moment of crash: _____
___Stopped ___Slowing ___Accelerating
Other vehicle (year, make, model) _____
Time of day: ___Daylight ___Dawn ___Dusk ___Dark
Road condition: ___Dry ___Damp ___Wet ___Snow
___Ice Other:_____
Head restraints: __None __Integral type __Adjustable type
__Up __Down __Don't know
If adjustable, was the position altered by the crash?
___Yes ___No
Was the seat back adjustment altered by the crash?
___Yes ___No
Was the seat broken? ___Yes ___No
Was the vehicle safety restraints used: ___Yes ___No
Did the air bag deploy? ___Yes ___No
If yes, were you struck? ___Yes ___No
If yes, where?_____
_____
Body position: ___Good ___Forward lean ___Other_____
Head Position: ___Forward ___Left ___Right ___Up
___Down

**Injury history general (con't)**

Hands: ___One on wheel ___Two on wheel ___N/A
Brakes applied? ___Yes ___No
Crash description:

_____
_____
_____
_____
_____
_____
_____
_____
_____

**Crash diagram:**

Aware of impending crash? ___Yes ___No
During the crash:
Did you strike any part of the vehicle? ___Yes ___No
If yes, describe: _____
Did vehicle strike any objects after the crash? ___Yes ___No
If yes, describe: _____
Wearing hat or glasses? ___Yes ___No
If yes, still on after crash? ___Yes ___No
Did you lose consciousness? ___Yes ___No
If yes, for how long? _____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s):
___None ___Minimal ___Moderate ___Major
Were there police on-scene? ___Yes ___No
If yes, was a report made? ___Yes ___No
Was your vehicle towed? ___Yes ___No
**TX=Treatment SX=Symtom(s)**

**After the crash:**

Symptoms: ___Headache ___Dizziness ___Nausea
___Confusion/disorientation ___Neck Pain ___Back Pain
___ Paresthesia(s): If yes, where?_____
Extremity pain: If yes, where?_____
When did SX first appear? ___Immediately
(describe which SX) _____hour afterward
Where did you go after the crash? ___Home ___Work ___Hospital
Mode of transportation:_____
Pvt. doctor: _____

**Emergency department:**
Radiographs: ___Yes ___No
Cat Scan/MRI: ___Yes ___No
Body parts imaged: _____
Results: _____
Lab work: ___Yes ___No
Additional Treatment: ___Cervical Collar ___Ice
Other_____
Medications:_____
Other:_____
Follow-up instructions:_____
_____
_____

**Treatment history:**

1) Dr: _____
Specialty _____ Date first seen_____
Referred by_____ TX type _____
TX frequency_____ TX duration_____
Currently treating? ___Yes ___No
Any disability? ___Yes ___No
If yes, describe_____
Special tests_____
Referred by_____
DidTX help? ___Yes ___No
Notes: _____
_____
_____

2) Dr: _____
Specialty _____ Date first seen_____
Referred by_____ TX type_____
TX* frequency_____ TX duration_____
Currently treating? ___Yes ___No
Any disability? ___Yes ___No
If yes, describe_____
Special tests_____
Referred by_____
Did TX help? ___Yes ___No
Notes: _____
_____
_____