SRQDC

Doctor of Chiropractic

Personal Information

Please Print

Name Date Pt #

Address

City State Zip

Email: DOB Sex M /F

Phone Cell/Text Work

May we contact you by phone at: Home / Cell / Text / Work **please circle all that apply**

May we leave a voice/text message? Y / N **please circle all that apply**

We will not leave a voice message concerning any medical information, only a "please return call" message.

If you do not wish to be contacted by phone we will mail any correspondence to the above address unless otherwise specified

Emergency contact ____phone_______________

Medical History

What is the reason for today's visit?

When did this condition begin? ____

Is this the first time you have experienced this condition? Y /N

If no, when was the first time? ____

Have you been treated for this condition before? Y / N

If yes, when___________________ by whom? ____

Please describe the treatment(s)

Is this condition related to an auto accident? Y / N **If yes, please complete auto accident information on last page.**

If your condition is accident related, are you involved, or do you intend to be involved, in any litigation related to this condition? Y / N

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Sarasota FL 34231
(941) 518-2247 Phone/text

Have you ever sought chiropractic care before? Y / N If yes, when? ______________________

For what condition(s)

____

____

Have you ever had any of the following conditions: **Please circle all that apply**

Back Pain	Loss of Balance	Incontinence
Neck Pain	Head Injury	Cancer
Headache	Thyroid Disorder	Night sweats
Knee Problems	Hormonal Disorder	Unexplained weight loss
Foot/Ankle Problems	Menstrual Disorder	Addiction
Shoulder Problems	Disorder of the Breast	Alcoholism
Hip Problems	High Blood Pressure	Depression
Joint Replacement	Diabetes	ADHD
Other joint problem	Heart Disease	Anorexia/Bulimia
Sciatica	Circulatory Disorder	Alzheimer's/Dementia
Numbness	Pneumonia	Parkinson's
Unusual sensation	Asthma	Down's Syndrome
Burn/Tingling sensation	COPD	Skin Rash
Fatigue	Tuberculosis	Broken Bones
Muscle weakness	Heart Burn / Indigestion	Osteoporosis
Loss of Smell	Gall Bladder disorder	Stress Fracture
Loss of vision	Inflammatory Bowel Disease	Auto Accident
Ringing in the Ears	Prostate Disorder	Other type of accident
Loss of hearing	Ovarian/Uterine Disorder	Surgery
Vertigo	Bladder or Bowel Disorder	STD's
Loss of Taste	Sexual Dysfunction	
Loss of Coordination		

Do you have any other conditions not listed above? Y / N

If yes, please explain

____

____

____

Are you currently taking any medications (including over the counter medications), nutritional supplements and vitamin /mineral supplements? Y / N

If yes, please list the medication/vitamin/supplement. For prescription medications please list the reason prescribed (if known). If you need additional space please use last page

____

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____

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Name Patient #

Has your condition prohibited you from performing any of your normal daily activities? Y / N

If yes, describe ____

____

Have you ever been hospitalized, including outpatient procedures? Y / N

If yes, please list all occurrences including dates, conditions and outcome. If you need additional space please use last page.

____

____

____

Do you use alcohol or tobacco? Y / N If yes, what type and how often.

____

Do you exercise regularly? Y/ N If yes, describe ______________________________

Please rate your dietary habits 1-10, 1 2 3 4 5 6 7 8 9 10

Poor **excellent**

Have you been involved in any previous accidents of any kind (personal injury, automobile accident, sports injury, work place injury)? Y / N If yes, please list include date, injury, and outcome. Please check any activities which aggravate your condition:

___ Standing___ Walking___ Sitting___ Lying down ___ Bending___ Lifting

___ Twisting ___ Coughing ___ Stretching

____

____

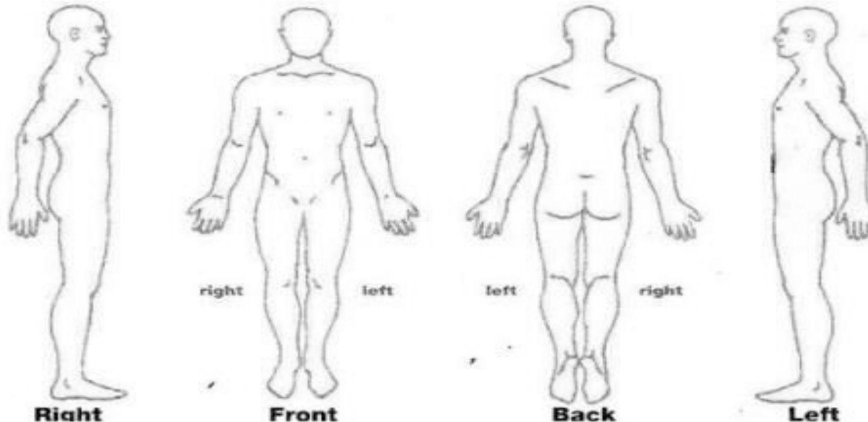
Is there anything else you feel your doctor should know to better serve your health care needs?

____

____

Using the following symbols, please mark your symptoms on the figure below.

b-burning; a-aching; w- weak; d-dull; o-feels odd; n-numb; t- tingling; p- pain; s-sharp



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Name ____ Patient # ______________

WORK HISTORY

What is your current occupation: _______________________________

Please describe the physical duties required by your job (i.e. regularly lifting 10 pounds, working with arms over head, sitting at a desk for 4 hours straight, etc):

____

____

____

As a result of your current condition are you currently prohibited from working or restricted in your duties? Y/N

If yes, has this restriction been placed upon you by another doctor? Y/N

If yes, please provide the name of the physician who has prescribed the work restrictions and give the nature of the restrictions:

____

____

____

Have you missed any work as a result of this condition? Y / N

If yes, please state how many days/hours have been missed and the reasons therefore:

____

____

____

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 ACCURATE INFORMATION IS IMPORTANT IN AIDING IN THE DIAGNOSIS AND TREATMENT OF MY CONDITION[S]. I FURTHER UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

____________________________ ________________________

Patient’s Signature Date

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