Family Chiropractic
Chiropractic Care & Injury Rehabilitation

830 E. Hwy. 434, Suite 3, Longwood, FL 32750
Phone 407-767-5700 * Fax 407-339-7204

Patient Information

Today's Date _____/_____/_____ Referred by: _____

Patient Name: First _____ Last _____ Mi _____

Parent/Guardian's Name (if patient is a minor): First _____ Last _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #(_____) _____-_____ Cell Phone #(_____) _____-_____ E-mail:_____

Work Phone #(_____) _____-_____ Occupation: _____ Employer: _____

Date of Birth: _____/_____/_____ Age: ____ Female ____ Male ____ Social Security #_____-_____-_____

Status: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Chief Complaint or Reason for today's visit: _____

How long have you had this condition? _____ Date of Onset: _____/_____/_____
Have you had this condition before? Yes ___ No ___ If yes, when? _____

What doctors have you seen for this condition? _____
What did they do? _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____

Is this Injury/Illness due to:
1. Auto Accident — Date of Accident: _____/ _____/_____
2. Work Injury — Date of Injury: _____/_____/_____
3. Other Injury/Illness — Date Symptoms Appeared: _____/_____/_____

Patient Resides With: Alone ___ Spouse ___ Parents ___ Children ___ Other _____

Do you own a vehicle? Yes ___ No ___ Any household family members that own vehicles? Yes ___ No ___

AUTO INSURANCE INFORMATION

Complete if you were recently in an auto accident.

Auto Insurance Co. Name: _____Insurance Phone # (_____) _____-_____

Insurance Co. Address: _____

Policy Number: _____ Claim Number: _____

Insured's Name: _____ Relation to Insured: _____

Attorney Name: _____ Phone Number (_____) _____-_____

Attorney Address: _____

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HEALTH INSURANCE INFORMATION
If you have Health Insurance, please present your insurance card and ID to front desk.

Health Insurance Name: _____ HMO ___ PPO ___

Health Ins. Address: _____

Health Ins. Phone # (_____) _____-_____ Your ID # _____ Group # _____

Insured's Name: _____ Relation to Insured: _____

Please mark X for present conditions, O for past conditions

____ Fractured Bones
____ Auto Accidents
____ 0-1 year ago
____ 2-5 years ago
____ More than 5
____ Other accidents & falls
____ Back Curvature
____ Arthritis
____ Diabetes
____ Swollen/Painful Joints
____ Convulsions, Epilepsy
____ Skin Problems
____ Cancer
____ Frequent Colds/Flu
____ Depression
____ Irritable
____ Anemia
____ Tremors
____ Allergies
____ Sinus Problems
____ Eating Disorders
____ Trouble Sleeping
____ Trouble Concentrating
____ Learning Disability
____ Mood Changes

____ Headaches
____ Pain/Stiff Neck R L
____ Numbness, Tingling, Pain in Arms/Hands/Fingers R L
____ Jaw Pain/TMJ R L
____ Head/Shoulders Feel Tired
____ Difficulty in Excessive (Standing, Walking, Bending, Riding, Twisting Lifting, Household Duties)
____ Shoulder Pain R L
____ Dizziness
____ Ringing in Ears R L
____ Hearing Loss R L
____ Fainting
____ Loss of Balance
____ Blurred Vision R L
____ Double Vision R L
____ Upper Back Pain/Stiffness
____ Mid Back Pain/Stiffness
____ Low Back Pain/Stiffness
____ Numbness, Tingling or Pain in buttocks, thighs, legs, feet, toes
____ Pain with cough/sneeze
____ Hip Pain R L
____ Foot Trouble R L

____ Chest Pain
____ Asthma
____ Lung Problems
____ Difficulty Breathing
____ Heart Problem
____ Stroke
____ High/Low Blood Pressure
____ Varicose Veins
____ Liver Trouble
____ Gall Bladder Trouble
____ Digestive Problems
____ Heartburn
____ Ulcers
____ Diarrhea/Constipation
____ Colon Trouble
____ Hemorrhoids
____ Prostate Problems
____ Impotence
____ Kidney Trouble
____ Menstrual Problems/PMS
____ Menopausal Problems
____ Pregnant (currently)
____ Bed Wetting
____ Ear Infections
____ AIDS/HIV

For the provider only: Diagnosis Codes: 1. _____ 2. _____ 3. _____ 4. _____