

NEW PATIENT INFORMATION

****NOTE: If this is a Workers' Compensation or Auto Accident Case, please tell Receptionist NOW before you start this form. ****

Date: _____ Name: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

If here from out of town: Local Address: _____

Phones: Daytime _____ Cell _____ Email _____

Birth Date: Mo _____ Day _____ Yr _____ Sex: _____ SS# _____

Married: _____ # of Children: _____ Spouse Name: _____

Business/Employer: _____ Type of Work: _____

Have you been treated here before? Yes _ No _ If so, when? _____

How did you find out about us? _____

(If referred by someone, please give us their name so we can thank them!)

MAJOR COMPLAINT: _____

Previous Chiropractic Care: _____

(Doctor's Name, Location, Last seen?)

Other Doctors seen for this condition: _____

Medications currently taking: Prescribed _____

Over the counter _____

Vitamins currently taking: Regularly _____

Occasionally: _____

Intake _____ How much, How often _____ Intake _____ How much, How often _____

Cigarettes _____ Coffee _____

Alcohol _____ Tea _____

Sugar _____ Drugs _____

Water _____ Exercise _____

FEMALES ONLY: Are you pregnant? Yes _ No _ Unsure _ Date of last period _____

Any other condition you have or symptom you are being treated for or that the doctor should know about? _____

Medical Insurance Company name: _____

ID No: _____ Group No: _____

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be responsible for payment.

Signature: _____ Relationship: _____ Date: _____

I authorize Family Life Health Center to render chiropractic care and treatments. If applicable, I give them permission to bill my insurance co. & accept payment on my behalf. I agree to be responsible for payment. Signature: _____ Date: _____

Please turn page over and fill in the back of the form >

CIRCLE ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

| | | | | | |
|---------------|--------------|--------------------|---------------|-----------------|-----------|
| Appendix Neck | Tonsils Legs | Gall Bladder Colon | Hernia Cancer | Heart C-Section | Back Eyes |
|---------------|--------------|--------------------|---------------|-----------------|-----------|

Other: _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE BEEN DIAGNOSED WITH:

| | | | | | |
|----------------|-------------|-------------|---------------|-----------------|--------------------|
| Appendicitis | Malaria | Chicken Pox | Alcoholism | Scarlet Fever | Tuberculosis |
| Diabetes | Pneumonia | Diphtheria | Cancer | Arthritis | Fibromyalgia |
| Whooping Cough | Typhoid | Rheumatic | Heart Disease | Mental Disorder | Venereal Infection |
| Measles | Fever | Fever | Small Pox | Polio | Epilepsy |
| Hepatitis | Mumps | Pleurisy | Flu | Eczema | Lumbago |
| Diverticulitis | Anemia | Goiter | AIDS | Bronchitis | |
| | Acid Reflux | Herpes | | | |

Other: _____

CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

Musculo-skeletal:

Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Clicking Jaw/Difficulty Chewing

Nervous System:

Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities

General:

Allergies
Loss of Sleep
Fever
Headaches/Migraines
Sore Throat
Ear Aches
Stuffy Nose
Varicose Veins
Ankle Swelling
Lung Problems/Congestion
Chest Pain
Shortness of Breath
Irregular Heartbeat
Heart Problems
Blood Pressure Problems

Gastro-Intestinal:

Poor/Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Trouble
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/Bloating After Meals
Heartburn
Black/Bloody Stool
Colitis

Genito-Urinary:

Bladder Trouble
Painful/Excessive Urination
Discolored Urine

Male/Female:

Menstrual Irregularity
Menstrual Cramping
Vaginal Pain/Infection/Discharge
Breast Pain/Lumps
Prostate/Sexual Dysfunction
Genital Herpes

Other:

Vision Problems
Hearing Difficulties
Dental Problems



Dear Patient,

Federal regulations require that we keep your original X-Rays at our clinic. If you need them for a second opinion exam by another doctor or for an IME (independent medical examination), please remember that we need time to get them copied. Please allow us at least a week to get them for you. X-Ray copies are at an additional cost to you personally.

If you need a copy of your medical records only, please allow us a week to get them for you.

Thank you for your cooperation and understanding in this matter.

Patient signature

Date

"Keeping you healthy and pain free for life"

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