Pensacola Chiropractic and Dry Needling

Patient Information

Name:_____Sex:_____Date:_____

Address:_____City:_____ State:_____Zip:_____

Phone:(Primary):_____(Secondary):_____Email:_____

Date of Birth:_____Age:_____ Social Security #:_____

Occupation:_____Employer's Name:_____

Emergency Contact:_____Phone:_____Relationship:_____

Previous Chiropractic Care:_____Date of Last Treatment: _____

Would you be willing to accept text reminders of upcoming appointments? Circle one: YES NO

History of Present Illness

Primary complaint:_____When did symptoms begin?_____

Describe the pain. (Circle all that apply): Dull Aching Sharp Shooting Burning Throbbing Deep Stabbing Nagging

Does this complaint radiate, travel or shoot to any areas of your body? If so, where? Arm L or R Leg L or R

Grade the intensity/severity (0-10) of your pain: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

How frequent is the complaint present?_____Does the pain wake you up at night?_____

Does anything aggravate your symptoms?_____

Does anything make your complaint better?_____

List any doctors/treatment you have seen for this condition:_____

Secondary complaint:_____When did symptoms begin?_____

Describe the pain. (Circle all that apply): Dull Aching Sharp Shooting Burning Throbbing Deep Stabbing Nagging

Does this complaint radiate, travel or shoot to any areas of your body? If so, where? Arm L or R Leg L or R

Grade the intensity/severity (0-10) of your pain: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

How frequent is the complaint present?_____Does the pain wake you up at night?_____

List any doctors/treatment you have seen for this condition:_____

Patient Signature: _____Date: _____

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Previous Health History

Current and Past Medical History

Please list any current medical conditions you have:_____

Please list any previous medical conditions you have:_____

Please list any previous injury or traumas:_____

Do you have any medical/surgical implants?_____

Females only: Is there a chance you may be pregnant?_____If yes, how far along?_____

Family History

List any medical conditions of your mother:_____

List any medical conditions of your father:_____

Surgical History

Surgery	Year

Social History

Do you drink Alcohol?	YES	NO	Average consumption: _____
Do you drink Caffeinated products?	YES	NO	Average consumption: _____
Do you smoke cigarettes?	YES	NO	Daily use in packs per day: _____
Are you a former smoker?	YES	NO	Estimated quit date: _____
Do you exercise?	YES	NO	How many times a day?

Additional Information: _____

Medication List

MEDICATION	STRENGTH/DOSE	DATE STARTED

Patient Signature: _____Date: _____

Please Circle ALL That Apply

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweating
Fainting
Dizziness
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Allergy
Wheezing
Neuralagia
Numbness or Pain in
Arms, Hands or Legs

GASTROINTESTINAL SYMPT.
Poor Appetite
Difficult Digestion
Excessive Hunger
Belching of Gas
Nausea
Vomiting
Vomiting of Blood
Pain Over Stomach
Distention of Abdomen
Constipation
Diarrhea
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

E.N.T.
Failing Vision
Nearsightedness
Farsightedness
Crossed Eyes
Eye Pains
Deafness
Earache
Noises
Nose Bleeds
Nasal Obstruction
Sore Throat
Hay Fever
Asthma
Dental Decay
Gum Trouble
Frequent Colds
Enlarged Thyroid
Nasal Drainage
Tonsillitis
Sinus Infection
Enlarged Glands

CARDIO-VASCULAR
Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Attack
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Previous Stroke

MUSCLE & JOINT SYMP.
Neck Pain
Low Back Pain
Swollen Joints
Tremors
Foot Trouble
Painful Tail Bone
Hernia
Spinal Curvature
Poor Posture

RESPIRATORY
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficult Breathing

GENITOURINARY SYMPT.
Frequent Urination
Painful Urination
Bloody Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

SKIN
Skin Eruptions
Itching
Bruising
Dryness
Sensitive Skin
Varicose Veins
Hives or Allergy

FOR WOMEN ONLY
Painful Menstrual Periods
Hot Flashes
Irregular Cycle
Cramps or Backache
Menopausal Symptoms

Patient Signature: _____ Date: _____

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Informed Consent

Informed Consent To Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care

I hereby request and consent to the performance of: physical examinations and evaluations required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine, any associated nutrition supplements, home healthcare products, on me (or on the patient named below for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by **Pensacola Chiropractic and Dry Needling**, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at any of the listed **Pensacola Chiropractic and Dry Needling.**

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel, the nature and purpose chiropractic adjustments and other procedures as well as home healthcare products and nutrition supplementation, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, sprains, swelling and bruising. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the procedure which the doctor feels at the time, based upon the facts then known, what is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at **Pensacola Chiropractic and Dry Needling**.

To be completed by patient:

_____

Print Patient's Name

_____

Signature of Patient

_____

Date

To be completed by patient's representative, if necessary, e.g., if patient is a minor or disabled.

Patient's name: _____

Representative's Name: _____

Signature of Representative: _____