

Auburndale Chiropractic, LLC
214 Main Street
Auburndale, Fl. 33823

Phone: 863-968-0088
Fax: 863-968-0181

MR# _____

PATIENT INFORMATION

Full Name _____ Birth Date _____ Gender: M F Race _____

Hispanic or Latino Y N Multi-Racial: Y N Preferred Language _____

Address _____ City _____ State _____ Zip _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M W D Sep SS# _____ - _____ - _____ Spouse Name _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Your Employer _____ Your Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Employer _____ Spouse's Occupation _____

Health Insurance _____ **No** _____ **Yes** **Company** _____

INSURANCE (please allow our staff to photocopy your Insurance Information and Drivers License)

This is necessary for audit and billing purposes

How did you hear about our office? _____

Did someone refer you? _____ Who? _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- If your account is turned over to a collection agency for non-payment you will be responsible for any cost incurred in collections of said balance. This could include collection agency fess of up to 50% of your outstanding balance, court costs and attorney fees.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

(Authorization expires 3 years from date above)



CASE HISTORY

FULL NAME: _____ DOB: _____ MR#: _____

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaint(s).

- 1. _____ How long? _____
- 2. _____ How long? _____
- 3. _____ How long? _____
- 4. _____ How long? _____

Is your condition(s) related to an accident? YES NO
Date of accident: _____ Type of Accident: Auto Work Related Other _____

What words best describe your present condition(s)? (ex. ache, burn, tingling, etc) _____

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

How intense is the problem? MILD MODERATE SEVERE

When does the problem occur? (ex. Standing, sitting, exercise, etc) _____

When is your condition most severe? _____

When is your condition least severe? _____

Is your condition: Getting worse Staying the same Getting better Comes & Goes
Other (explain) _____

Have you ever had the same or similar conditions in the past? YES NO
IF YES, EXPLAIN _____

What makes your condition feel worse? _____

What makes your condition feel better? _____

What activities are difficult because of your condition(s)? _____

Have you seen any other health care provider for your present condition? YES NO
Who? _____

Do you have any known allergies? (Medication/Food/Seasonal) YES NO
IF YES, EXPLAIN _____

Are you currently taking medications YES NO
BRAND NAME OR GENERIC NAME _____

Do you have a pacemaker? YES NO
Are you or could you be pregnant? YES NO
Do you currently smoke? YES NO
Have you ever smoked? YES NO

Are you experiencing or do you have any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> A sore throat that won't heal | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Persistent cough/hoarseness |
| <input type="checkbox"/> Any bleeding /discharge | <input type="checkbox"/> Lump/thickening anywhere | <input type="checkbox"/> Wart/mole changes |
| <input type="checkbox"/> Bladder/bowel problems | <input type="checkbox"/> Night pain | <input type="checkbox"/> Weight loss without trying |
| | | <input type="checkbox"/> None of the above |