

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 |