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)

Auburndale Chiropractic, LLC
214 Main Street - Auburndale, Fl. 33823
863-968-0088

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?

□A sore throat that won't heal
□Any bleeding /discharge
□Bladder/bowel problems
□Difficulty swallowing
□Lump/thickening anywhere
□Night pain
□Persistent cough/hoarseness
□Wart/mole changes
□Weight loss without trying
□**None of the above**