File Number: _____

BONITA BEACH
CHIROPRACTIC

Patient Information

Today's date: / / Patient Date of Birth: / /

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

Patient Name *(Last, First, MI)*: _____

Patient Signature: _____

Local Address: _____
Street City State Zip Code

Permanent Address: _____
Street City State Zip Code

Contact Method:
How would you like for us to contact you? ☐ Primary Phone ☐ Secondary Phone ☐ Email

Primary Phone: ( ) - Secondary Phone: ( ) -

Email address: _____
By providing my email address, I authorize BBC to contact me via the email address(es) provided.

Gender: ☐ Male ☐ Female ☐ Unspecified Age: _____

Employment Status: ☐ Student FT/PT ☐ Employed ☐ Retired ☐ Self-Employed ☐ Other

Occupation: _____

Have you had previous chiropractic care? ☐ Yes ☐ No Date of last care _____

How did you hear about us? ☐ Referral ☐ Advertisement ☐ Internet

Who may we thank for referring you? _____

In case of emergency, Please notify: _____ Phone # _____

What brings you to our office? Please provide as much detail as possible.

Current Complaint: _____ Date symptoms first began: _____

How symptoms began: _____

How often do you experience these symptoms?

☐ Constant (100%) ☐ Frequent 75% ☐ Intermittent (50%) ☐ Occasional (25%) ☐ Rare (10%)

Have you experienced the same/similar symptoms before? When? _____

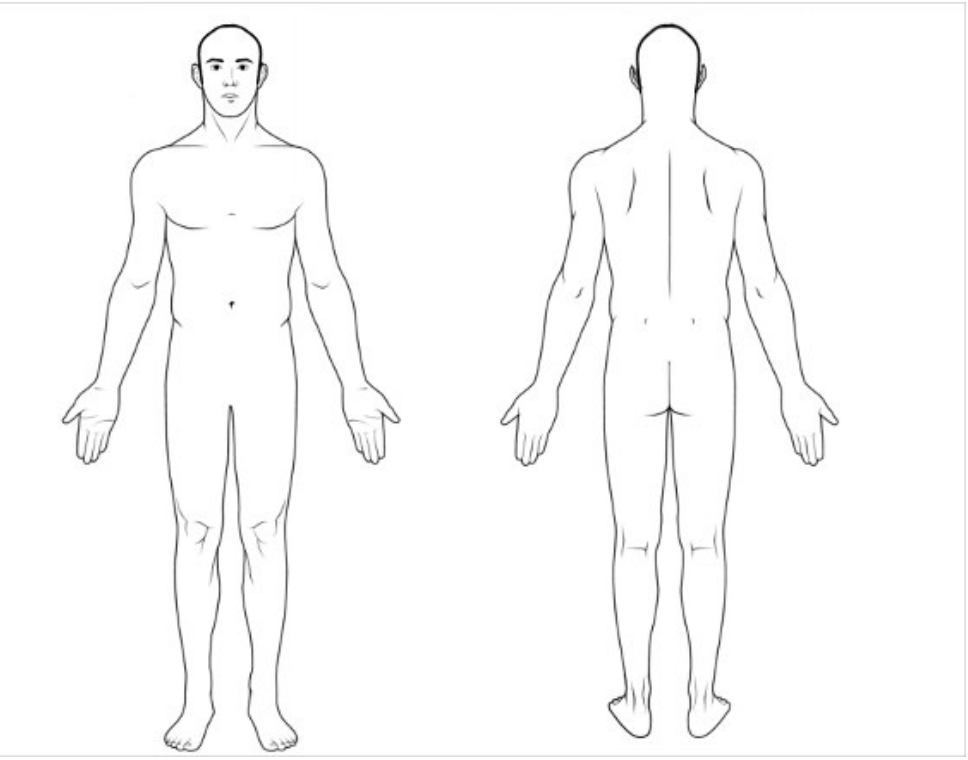
Have you been to another doctor for this problem? Where? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Other: _____

Do you have any numbness/tingling? Where? _____

Does pain radiate? Where? _____

Does anything worsen or improve the pain?_____



Please mark <u>all</u> areas of complaint on the body diagram using the following indicators:

A-ache D-dull B-burning
T-tingling N-numb S-stabbing
O-other

Please rate the intensity of each symptom on a scale of 1-10, with 1 being mild and 10 being extreme

Current medications/vitamins: _____

_____

Medication allergies: _____

Have you had and X-ray, MRI, or CT in the past month? ☐ Yes ☐ No _____

Height (inches): _____ Weight (pounds): _____

Health History

Check the following conditions that apply to you, past and present. Add any additional comments to clarify the condition.

GENERAL
___ Lethargy/Weakness
___ Recurring Fever
___ Recent weight loss or gain
___ Dizziness
___ Fever/Chills

CARDIOVASCULAR
___ Chest pain/tightness
___ Heart attack
___ Shortness of breath
___ Palpitations
___ Swelling of hands/feet
___ High blood pressure
___ High cholesterol/triglycerides
___ Heart murmur
___ Blood clots
___ Pacemaker
___ Mitral valve prolapse
___ Congenital heart defects
___ Rheumatic fever
___ Leg pain upon walking
___ Varicose veins
___ Excessive bruising
___ Coronary artery disease

NEUROLOGICAL
___ Fainting
___ Memory loss
___ Poor balance
___ Numbness/Tingling
___ Epilepsy/Seizures
___ Stroke
___ Tremors
___ Head injury
___ Sleep issues
___ Weak muscles
___ Loss of smell/taste
___ Temporary loss of vision

PSYCHIATRIC
___ Alzheimer's
___ Insomnia
___ Difficulty concentrating
___ Memory loss/Confusion
___ Depression/Anxiety
___ Agitation/Irritability
___ Suicidal thoughts
___ Chemical dependency

HEENT
___ Headaches/Migraines
___ Eye/Vision problems
___ Glasses/Contacts
___ Nose bleeds
___ Eye surgery
___ Cataracts
___ Glaucoma
___ Sore throat
___ Hoarseness
___ Swollen glands
___ Nose/Sinus congestion
___ Ear/Hearing problems
___ Dental/Gum problems
___ TMJ problems
___ Postnasal drip

RESPIRATORY
___ Persistent cough
___ Spitting up blood
___ Asthma/wheezing
___ Exercise intolerance
__ Sleep apnea
___ Emphysema
___ Tuberculosis
___ Pneumonia

MUSCULOSKELETAL
___ Arthritis
___ Joint pain/swelling
___ Neck pain
___ Back pain
___ Trauma
___ Osteoporosis
___ Scoliosis
___ Cramping
___ Fractures
___ Implants/Plates/Screws
___ Hip disorders
___ Knee injuries
___ Foot/Ankle pain
___ Shoulder problems
___ Elbow/Wrist pain
___ Gout

ALLERGIES
___ Seasonal
___ Medication
___ Food

SKIN/HAIR
___ Skin trouble/Rashes
___ Flushing
___ Excessive acne
___ Eczema
___ Psoriasis
___ Skin cancer
___ Skin pigmentation issues
___ Change in hair/nails
___ Easy bruising

GASTROINTESTINAL
___ Loss of appetite
___ Nausea/Vomiting
___ Diarrhea
___ Constipation
___ Abdominal pain
___ Stomach ulcer
___ Bloating/Cramping
___ Heartburn
___ Hemorrhoids
___ Hepatitis/Liver disease
___ Cirrhosis
___ Jaundice
___ Gallbladder problems
___ Pancreatitis
___ Change in bowel habits

BLOOD
___ Anemia
___ Bleeding
___ Bruising
___ Blood clots
___ Past transfusions
___ Leukemia
___ Lymphoma
___ HIV/AIDS
___ Sickle cell

ENDOCRINE
___ Diabetes
___ Thyroid problems
___ Sweating
___ Heat/Cold intolerant
___ Weight loss/gain
___ Frequent urination
___ Excessive thirst
___ Change in appetite
___ Hair changes
___ Hyperparathyroidism
___ Hormonal/Glandular concerns
___ Testosterone deficiency
___ Cushing's syndrome
___ Steroid treatments

URINARY
___ Painful/Frequent urination
___ Incontinence
___ Hesitancy
___ Urgency
___ Blood in urine
___ Kidney stones
___ Urinary infections
___ Genital/Bladder/Urinary complaints

Female
___ Hot flashes
___ Menopause

Comments regarding health history: _____

_____

_____

_____

Surgeries: _____

_____

Illnesses: _____

_____

Accidents/Injuries/traumas: _____

_____

Family health history: _____

_____

Recreational activities/hobbies: _____

_____

Additional comments regarding your health and well-being: _____

_____

I have read the above information, and certify it to be true and accurate to the best of my knowledge. I authorize Bonita Beach Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Signature _____ Date _____