

Confidential Patient Information

Name: _____ ☐ Male ☐ Female Age: _____ Date of Birth: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail: _____
 Occupation: _____ Employer: _____
☐ Married (Spouse's Name _____)
 Children's Names/ Ages: _____
 Whom may we thank for referring you? _____
 Emergency Contact Person: _____ Phone Number: _____
 Have you had Chiropractic care before? ☐ No ☐ Yes- When/Where? _____
 If you are leaving area for extended periods, when are you leaving: _____ Returning: _____

HOW CAN WE SERVE YOU?

1. I have no complaints, I am here for a wellness check up. ☐
Subluxations (spinal misalignments) cause most of the unwanted health conditions people suffer from everyday. Subluxations affect your nervous system, which affects your health.
2. What is your first health concern? _____ First occurrence date: _____
 Subluxations irritate nerve fibers causing various sensations. Which describes yours?
☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching ☐ Stabbing ☐ Numbness ☐ Other: _____
 Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is yours concern? ☐ Constant ☐ Occasional
3. What is your second health concern? _____ First occurrence date: _____
 Subluxations irritate nerve fibers causing various sensations. Which describes yours?
☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching ☐ Stabbing ☐ Numbness
 Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is your concern? ☐ Constant ☐ Occasional
- Please list medications you are currently taking (prescriptions AND over the counter).
 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
 Please list any/all surgeries: _____

Neurological <input type="checkbox"/> headaches <input type="checkbox"/> numbness, where? _____ <input type="checkbox"/> Irritable <input type="checkbox"/> nervousness <input type="checkbox"/> tremors <input type="checkbox"/> allergies <input type="checkbox"/> seizures <input type="checkbox"/> depression <input type="checkbox"/> fatigue <input type="checkbox"/> sleeping problems <input type="checkbox"/> unexplained weight loss <input type="checkbox"/> loss of balance <input type="checkbox"/> dizziness	Gastro Intestinal <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> colon trouble <input type="checkbox"/> loss of bowel control <input type="checkbox"/> difficult digestion <input type="checkbox"/> acid reflux <input type="checkbox"/> nausea/vomiting Genito-Urinary <input type="checkbox"/> bed wetting <input type="checkbox"/> frequent urination <input type="checkbox"/> loss of urine control <input type="checkbox"/> kidney infection <input type="checkbox"/> prostate trouble <input type="checkbox"/> failing vision	Respiratory <input type="checkbox"/> asthma <input type="checkbox"/> chronic cough <input type="checkbox"/> sleep apnea Do You Have <input type="checkbox"/> cancer <input type="checkbox"/> heart disease <input type="checkbox"/> diabetes For Women Only <input type="checkbox"/> menstruation <input type="checkbox"/> infertility <input type="checkbox"/> Pregnant Due Date _____	Cardio-Vascular <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> rapid heartbeat <input type="checkbox"/> slow heartbeat <input type="checkbox"/> swelling of the ankles <input type="checkbox"/> chest pain Eyes, Ears, Nose & Throat <input type="checkbox"/> frequent cold <input type="checkbox"/> hearing loss <input type="checkbox"/> asthma <input type="checkbox"/> ear aches <input type="checkbox"/> ringing in the ears <input type="checkbox"/> sinus infections <input type="checkbox"/> thyroid trouble	OFFICE USE ONLY M W T T H F TIME: REF _____ NPE _____ CERx _____ LBx _____ OFFICE USE: Medicare _____ In _____ Other: _____
--	---	--	---	---

Upper Cervical Health Centers
12651 McGregor Blvd., STE 102
Fort Myers, FL 33919
(239) 243-8810

**PATIENTS'S AFFIRMATION OF RECEIPT
OF PATIENT'S STATEMENT OF PRIVACY RIGHTS**

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health information, as a patient of this practice.

Affirmed,

Patient Name

Date



X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests and x-rays.

Patient Signature

Date

Witness

Date

FEMALES ONLY:

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in anyway.

Patient Signature

Date

Witness

Date