CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: _____/_____/_____
(Last Name) (First Name) (MI)

Preferred Name: _____ Age: _____ Date of Birth: _____ S.S.#: _____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone or other)

E-mail address: _____ Gender: female _____ male _____
I give Eustis Chiropractic and its representatives permission to communicate to me via email

Are you (check one): Single ____ Married ____ Other ____ Partner's Name: _____

Occupation: _____(circle) Full time/ Part time /Student/ Retired

Employer / School: _____
Address: _____/_____/_____/_____
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact _____
(Name) (Relationship)

_(_____)_____(_____)_____
(Day Phone) (Evening Phone)

Referred By:_____ Drivers License#:_____

Insurance Information – Please provide copy of front and back of Insurance card.
□ **Group Insurance:** Insurance Co: _____ON FILE_____

Insured Full Legal Name: _____ Date of Birth: ___/___/___

Insured's Address:_____/_____/_____/_____/(____)_____
(street / PO Box) (City) (State) (Zip Code) (Phone Number)

□ **MVA:** Date of MVA: _____ State MVA occurred: _____ Claim number: _____
Insurance Co: _____ Claim submitted □ Y □N Adjuster: _____ Phone: (_____)_____
Attorney's Name: _____ Phone: ( )_____ PIP Coverage: _____

Do you have any secondary or additional Insurance plans? □ Yes □ No Name: _____

By signing below, I verify that the above information is correct to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

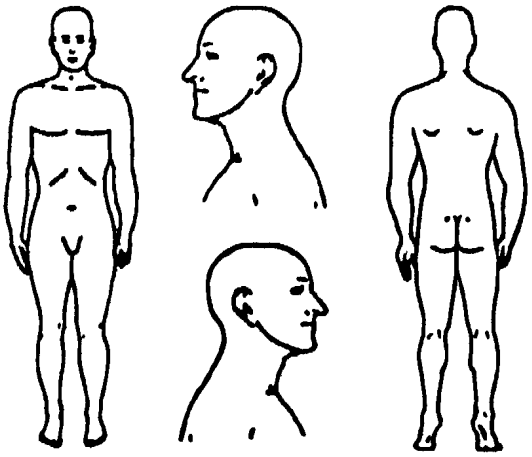
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Patient _____ Today's Date_____

Name:_____ Date:_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your MAJOR complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO If Yes when:_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Name:_____ Date:_____

Do you have a SECOND complaint?

If so what:_____Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Preferred Language: _____

Smoking Status:

Current Every Day Smoker___ Current Some Day Smoker___ Former Smoker___

Never Smoked____

Race:

American Indian or Alaska Native___ Asian___ Black or African American___

Native Hawaiian Or Other Pacific Islands___ White___ Patient Declined To Provide___

Ethnicity:

Hispanic Or Latino___ Not Hispanic or Latino___ Patient Declined To Provide___

PAST CHIROPRACTIC CARE:

Have you ever had chiropractic care? ! No ! yes
When? _____Why? _____
Where? _____
Were X-rays taken? ! No ! Yes
When was your last adjustment? _____

CONFIDENTIAL QUESTIONNAIRE

IF CIRCLE Y PLEASE CIRCLE WHAT YOU ARE SAYING YES TO IF CHOICES

Name:_____ Date:_____

Y N Do you have any pain, numbness, tingling, burning, or other abnormal sensations into your arms, into your hands or fingers or down your leg into your feet or toes?

Y N Do you have any weakness in your arms, hands, fingers, legs, feet, or toes?

Y N Do you have any pain when you cough, sneeze, or have a bowel movement or laugh?

Y N Do you have any trouble controlling your bowels or bladder?

Y N Does pain wake you up at night? If so, does it wake you up from a deep sleep, or does it wake you when you change positions?

Y N Does changing positions, rest, or anything else relieve the pain?

Y N Do you have a history of cancer or other serious disease such as lung, liver, heart, kidney, bladder, bowel, HBP, thyroid, hepatitis, HIV, or diabetes?

Y N Is there a family history of serious illness?

Y N Have you had any blood in your stool or urine?

Y N Is your cough productive, and if so, what is the color of the sputum?

Y N Have you had a fever recently or do you have a fever now?

Y N Have you had any weight loss or gain? If yes, was it diet related? Y N

PATIENT CASE HISTORY

Date:_____

Name:_____ Date of Birth:_____

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

List ALL **Medications** you are taking: _____

_____

_____

_____

Medications Allergic To:_____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Have you had any auto or other accidents? □ No □Yes

Describe: _____

Date of last physical examination: __ _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____ _____