Suncoast Chiropractic & Neurological Diagnostic Center

MEDICARE / MEDICAID / HEALTHEASE / CASH / GROUP

PERSONAL HISTORY

TODAY'S DATE:_____/____/____

FIRST NAME: _____MI:_____LAST:_____

NICKNAME: _____ BIRTH DATE: ____/_____/_____

ADDRESS: _____CITY: _____ STATE: ____ZIP:_____

SS#:_____/_____/_____ SEX: M / F

HOME PHONE#: (_____) _____-_____

WORK#: (_____)__ ____-_____

CELL #: (_____)_ _____-_____

PREFERRED CONTACT NUMBER: (circle one) HOME / WORK / CELL

CELL PROVIDER: _____ i.e. (AT&T - VERIZON - T-MOBILE – SPRINT)

EMAIL ADDRESS: _____

EMPLOYER NAME: _____OCCUPATION: _____

MARITAL STATUS: (circle one) M / S / W / D SPOUSES NAME: _____

NAME of EMERGENCY CONTACT: _____RELATIONSHIP:_____

PHONE NUMBER of EMERGENCY CONTACT: _____

DATE PROBLEM STARTED:_____

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS YOU ARE HAVING NOW:

_____ HEADACHES RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ BLURRED VISION - RIGHT EYE - LEFT EYE - BOTH EYES

_____ DIZZY SPELLS - HOW OFTEN _____

_____ RINGING IN EARS - RIGHT EAR - LEFT EAR - BOTH EARS

_____ JAW PAIN RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ NECK PAIN RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ NUMBNESS & TINGLING OR PAIN IN ARMS RIGHT ARM - LEFT ARM - BOTH ARMS

_____ PAIN ABOVE SHOULDER BLADES RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ PAIN BETWEEN SHOULDER BLADES RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ PAIN BELOW SHOULDER BLADES RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ LOW BACK PAIN ABOVE THE WAIST RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ LOW BACK PAIN AT THE WAIST RIGHT SIDE - LEFT SIDE - BOTH SIDES

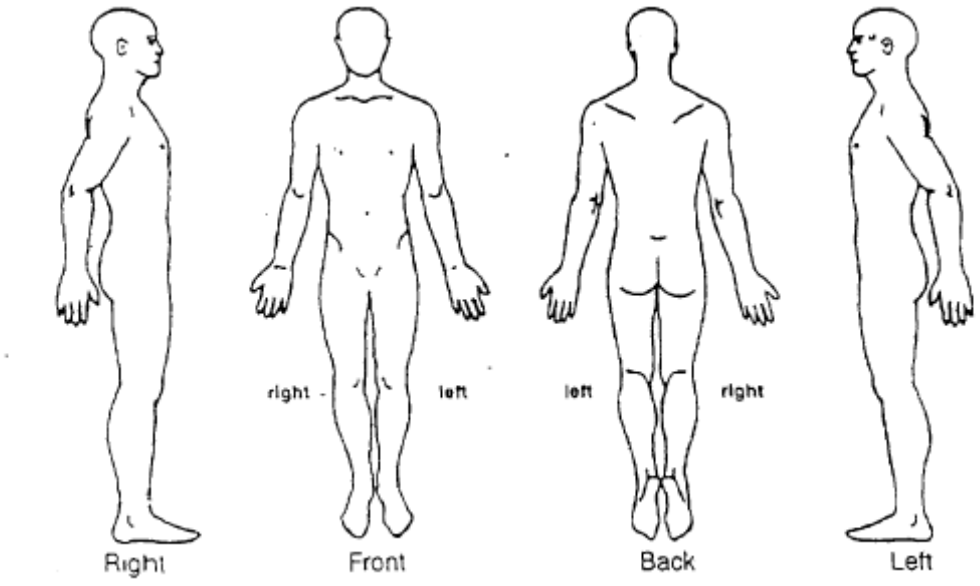
_____ LOW BACK PAIN BELOW THE WAIST INTO THE TAIL BONE RIGHT SIDE - LEFT SIDE - BOTH SIDES

_____ NUMBNESS & TINGLING / PAIN INTO LEGS RIGHT LEG - LEFT LEG - BOTH LEGS

_____ OTHER - PLEASE DESCRIBE_____

Please mark the area of injury or discomfort:

On the pictures below mark: P = PAIN N = NUMBNESS T= TINGLING



PLEASE CHECK HOW YOUR PROBLEM STARTED:

_____ GRADUAL ONSET - GETTING WORSE

_____ SUDDEN ONSET FROM AND ACCIDENT OR FALL

IF AN ACCIDENT , PLEASE DESCRIBE ONSET OF SYMPTOMS _____

_____

_____

HAVE YOU SEEN ANY OTHERR DOCTORS FOR THIS CURRENT PROBLEM? Y / N IF YES, PLEASEE LIST DOCTORS NAME AND ADDRESSES:_____

_____

DATE FIRST SEEN: _____ DATE LAST SEEN _____

WERE YOU PRESCRIBED MEDICATIONS? Y / N IF YES, PLEASE LIST: _____

_____

WERE X-RAYS TAKEN OR ANY OTHER TESTS PERFORMED? Y / N PLEASE LIST: _____

_____

PAST MEDICAL HISTORY:

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT BEFORE? Y / N IF YES, DATE OF ACCIDENT_____

WERE YOU INJURED? Y / N IF YES, WHERE?_____

DID YOU RECEIVE MEDICAL AND/OR CHIROPRACTIC TREATMENT? Y / N PLEASE LIST DOCTORS NAMES AND ADDRESSES:_____

_____

DID YOU SUSTAIN A PERMANENT IMPAIRMENT OR DISABILITY? Y / N IF YES, WHAT AREA AND HOW MUCH?

_____

HAVE YOU EVER BEEN INJURED ON THE JOB? Y / N IF YES, DATE OF ACCIDENT _____

WAS A REPORT MADE: Y / N BY WHOM _____ WAS AN INSURANCE CLAIM MADE Y / N

WHAT AREA WAS INJURED? _____

DID YOU RECEIVE MEDICAL AND/OR CHIROPRACTIC TREATMENT? Y / N PLEASE LIST DOCTORS NAMES AND

ADDRESSES:_____

_____

DID YOU RETURN TO WORK? Y / N (PLEASE CIRCLE) FULL TIME / PART TIME

DID YOU RECEIVE A PERMANENT IMPAIRMENT OR DISABILITY? Y / N IF YES, WHAT AREA AND HOW MUCH?____

_____

PLEASE LIST ANY MINOR OR MAJOR SURGERIES:

TYPE OF PREVIOUS SURGERY	DATE	CITY AND STATE WHERE PERFORMED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY FRACTURES OR BROKEN BONES:

AREA OF FRACTURE	DATE	DOCTOR WHO TREATED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE CIRCLE **YES OR NO**:

HEART ATTACK **Y / N** – DATE_____ STROKE **Y / N** – DATE_____ CANCER **Y / N**– DATE _____

If Cancer when _____ what area_____ were you treated? **Y / N**

Are you still under care? **Y / N** With whom? _____

Do you have a pacemaker? Y / N

FAMILY HISTORY: Is your Mother ALIVE / DECEASED
Is your Father ALIVE / DECEASED

Please list any family history of: **MOTHER / FATHER / SPOUSE / CHILDREN**

HEART PROBLEMS____ HIGH BLOOD PRESSURE ____
DIABETES ____ EMPHYSEMA ____
STROKE ____ ANY OTHER ILLNESS _____
CANCER ____

WHAT IS YOUR?

HEIGHT _____ WEIGHT_____ AGE _____ GENDER: MALE / FEMALE

Suncoast Chiropractic & Neurological
Diagnostic Center
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Crystal River, Florida 34429
(352)563-6471

LIST OF MEDICATIONS AND/OR ALLERGIES

PATIENT NAME_____

ANY KNOWN ALLERGIES_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF DRUG:	DOSAGE:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____