COLLIER CHIROPRACTIC AND ACCIDENT REHABILITATION CENTER

PLEASE PRINT

GENERAL INFORMATION

PATIENT LAST NAME_____FIRST NAME_____

ADDRESS_____CARE OF_____
(Parent or financially responsible person)

CITY_____STATE_____ZIP_____PHONE (WORK)_____

DRIVER'S LIC.#_____NO. CHILDREN_____PHONE (HOME)_____

OUT OF STATE ADDRESS_____PHONE_____

SPOUSE'S NAME_____SPOUSE's EMPLOYER_____ATIVE LANGUAGE_____

SEX M F MARRIED SINGLE WIDOWED DIVORCED DATE OF BIRTH SSN_____
(please circle) / /

EMAIL ADDRESS_____

We will never sell or rent your email address to anyone. We value your privacy. Used for internal communication purposes only.

PATIENTS EMPLOYER'S NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____OCCUPATION_____

EMPLOYED

FULL TIME PART TIME RETIRED NOT EMPLOYED

STUDENT

FULL TIME PART TIME NON STUDENT

INSURANCE INFORMATION

PRIMARY INSRUANCE COMPANY NAME_____

MEMBERSHIP/CERT #_____POLICY/GROUP#_____

NAMES ON CARD_____RELATIONSHIP TO INSURED_____

SECONDARY INSRUANCE COMPANY NAME_____

MEMBERSHIP/CERT #_____POLICY/GROUP#_____

NAMES ON CARD_____RELATIONSHIP TO INSURED_____

RELEASE AND ASSIGNMENT

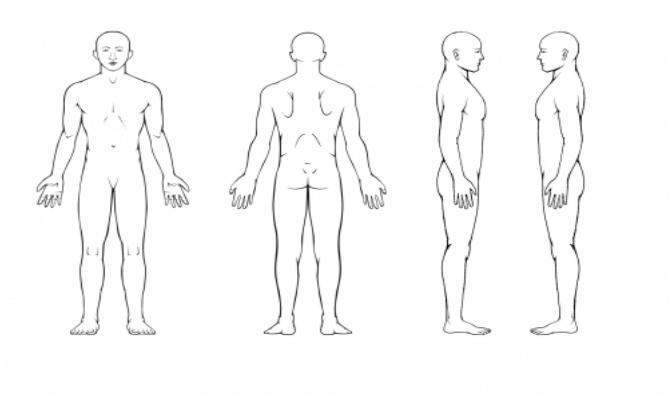
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

PATIENT'S SIGNATURE_____DATE_____

Patient Name:_____

Collier Chiropractic Patient History

Please mark the exact location of your pain/discomfort on the diagram below



Major complaint _____

_____

How did this condition develop (What caused it? How did it start? Have you had it previously)_____

_____

What makes this condition better and worse_____

_____

Have you received treatment for this condition? Yes or No (circle one) If yes, where, and what were the results?_____

_____

Type of pain experienced? (circle all that apply). Numbness Tingling Burning Radiating Throbbing

When is your pain at its worst Morning Afternoon Night Constant

When is your pain at its best Morning Afternoon Night Constant

Any other associated symptoms with your current condition (Eg headaches)_____

_____

Any previous surgeries, hospitalizations, infections/immunizations, trauma, allergies_____

_____

Family history of current condition, cancer, diabetes and cardiovascular disease_____

_____

Do you smoke, and how much?_____

Current Occupation_____
_____

Sleep habits, number of hours?_____

Sexual activity/STD's?_____

Do you take any prescription, over the counter or recreational drugs yes/no_____
_____

Do you consume alcohol, how much?_____

Diet (all american, vegan, food intolerances)_____

Exercise (how much and how often)_____

Have you ever been in an automobile accident?_____

Any chiropractor consulted in the past? Yes or No (circle one) If yes who, when and what for?_____
_____

Collier Chiropractic And Accident Rehabilitation Center
2180 Immokalee Road Suite 2012
Naples FL 34110

New Patient Questionnaire

Name:_____ **Date:**_____

Comprehensive Review of Systems: Circle all those that apply

Constitutional: Fevers, night sweats, poor appetite, unexplained weight loss or gain, insomnia, fatigue, excessive daytime sleepiness **NONE**

Current weight:_____ Weight 1 year ago_____

Height_____ Height Loss? Yes or No

Eyes: Glasses or contact lenses, eye pain, dry eyes, excessive tearing, double vision, light sensitivity, cataracts, glaucoma, other visual disturbances **NONE**

Ears: Hearing loss, hearing aid right ear_____ left ear____, ringing in ears, sensitivity to noise, ear ache, balance disturbance, dizziness, vertigo, recurrent ear infections, excessive ear wax **NONE**

Nose: Frequent colds, nasal congestion, recurrent or chronic sinusitis, nosebleeds, deviated septum, nasal polyps, loss of sense of smell **NONE**

Mouth: Dry mouth, bleeding gums, dentures, mouth ulcers, altered taste, loss of sense of taste **NONE**

Throat: Frequent sore throats, hoarseness, difficulty swallowing **NONE**

Cardiovascular: High blood pressure, low blood pressure, heart murmur, rheumatic fever, mitral valve prolapse, palpitations, shortness of breath, leg cramps, swelling of feet or ankles, varicose veins, thrombophlebitis, chest pain, angina, heart attack, congestive heart failure, heart surgery. **NONE**

Respiratory: Asthma, wheezing, bronchitis, pneumonia, chronic cough, emphysema/COPD, excessive phlegm production, coughing blood, shortness of breath on minimal exertion, sleep apnea, pain with deep breathing **NONE**

Gastrointestinal: Chronic heartburn/indigestion, nausea, vomiting, food intolerance, hiatal hernia, gastric reflux, ulcer, gallstones, jaundice, cirrhosis, abdominal or umbilical hernia, hemorrhoids, blood in stool, irritable bowel syndrome, diverticulitis, abdominal pain, bloating, constipation, laxative or enema dependence, chronic diarrhea, fecal incontinence. **NONE**

Urinary: Excessive or frequent urination, painful urination, blood in urine, recurrent urinary infections, urethral discharge, difficulty starting or stopping stream, incontinence, kidney or bladder stones, kidney disease, prostate **NONE**

Genitoreproductive: Impotence, sexually transmitted diseases, pregnant or possibly pregnant, premenstrual syndrome, endometriosis, irregular menses, last menstrual period__/__/__. Menopausal symptoms, age oat menopause, post-menopausal bleeding, discharge, itching, sores, painful intercourse, decreased libido, number of pregnancies___. Miscarriages or abortions, last PAP smear __/__/__ **NONE**

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New Patient Questionnaire

Name:_____ **Date:**_____

Comprehensive Review of Systems: Circle all those that apply

Musculoskeletal: Neck pain, back pain, painful limb, generalized muscle aches, muscle spasms, joint pain, swelling or stiffness, fractures, dislocations, arthritis, gout, restricted joint motion, weakness **NONE**

Breasts: Nodule or mass, thickening, dimpling, redness, pain or discomfort, nipple discharge, fibrocystic disease, breast biopsy or breast cancer, mastectomy ___right,___left. Breast reduction/augmentation **NONE**

Skin: Rashes, recurrent lesions, rosacea, chronic ulcer, pressure sore, psoriasis, itching, pigment changes, nail changes, thinning hair, hair loss, photosensitivity, Raynaud's Phenomenon, skin cancer **NONE**

Neurologic: Fainting spells, dizziness, incoordination, difficulty walking, falls, tremor, involuntary movements, slurred speech, tingling/numbness, paralysis, stroke, spinal cord injury, head injury or concussion, confusion, changes in memory, change in behavior or personalitity, headaches, seizures. **NONE**

Psychiatric: Nervousness, anxiety, panic disorder, claustrophobia, agoraphobia, post-traumatic stress disorder, victim of abuse, attention deficit disorder, hyperactivity, compulsive behavior, uncontrollable anger, depression, hallucinations, suicidal or homicidal thoughts, psychiatric treatment or hospitalizations. **NONE**

Current or past use:
Recreational drug use:_____
Prescription drug dependence:_____
Alcohol dependence withdrawal or treatment:_____

Endocrine: Heat or cold intolerance, excessive thirst or hunger, thyroid problem, diabetes, hypoglycemia, excessive sweating. **NONE**

Hematologic: Anemia, easy bruising, prolonged bleeding, history of transfusion, cancer, chemotherapy, radiation therapy, swollen glands/lymph nodes. **NONE**

Allergy/Immunology: food allergies_____, lactose intolerance, seasonal allergies, latex allergy, dermatitis, eczema, adverse reaction to vaccination, contrast, antibiotics or other drugs_____, impaired immunity, herpes, shingles. **NONE**

Surgical History:

_____
_____
_____

RELEASE OF PATIENT RECORDS AUTHORIZATION

I heareby authorize_____to release a copy of my patient records, x-rays or other diagnostic imaging containing protected health information to:

COLLIER CHIROPRACTIC AND ACCIDENT REHABILITATION CENTER INC

FAX # (239) 594-9976

This authorization is given pursuant to Florida Statue 456.057 and HIPAA regulations. I understand that Florida Statue 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____

Patient's or Patient Legal Representative's Name – PRINT CLEARLY Patient's Date of Birth

_____

Patient's or Patient's Legal Representative's Signature

_____Date Signed

Specific description of information to be disclosed:

_____