FLORIDA CHIROPRACTOR

5621 Central Avenue, St Petersburg, FL 33710
phone: 727-345-4242 | fax: 727-341-2929
www.FloridaChiropractor.com

Welcome to Florida Chiropractor!
Please take a few moments to provide us with the following information. If there is any important information that is not covered in the questionnaire, please bring it to the attention of the doctor. Thank you!

Your name:	Social Security #:
Mailing Address:	Date of Birth: Age:
City:	State: Zip:
Home Phone #	Cell Phone #
Work Phone #	E-Mail
Sex: M ( ) F ( )	If Female, are you pregnant? Y ( ) N ( )
Any Children?	How Many?
How did you find out about our office:	
1) Referral from a friend/relative/acquaintance ( )	2) Yellow Pages ( )
3) Other Advertisement ( )	4) Drive By ( )
5) Web ( )	6) Other ( )

Have you had previous chiropractic care?_____ When?_____

The reason for today's visit is:_____

_____

When did this condition begin?_____ What caused this condition?_____

Is this condition: ___getting worse, ___staying the same/constant, ___coming & going, ___getting better

Have you had this or a similar condition in the past: Yes ___ No ___

Have you noticed a recent change in your:

1) Bowel movements Yes ___ No ___ 2) Urination Yes ___ No ___

Have you experienced any recent fevers? Yes ___ No ___ Any other health changes? Yes ___ No ___

If yes, please explain_____

Please list any relative surgeries, traumas or major health conditions you have had and explain:

_____

Please list any medications you presently take on a regular basis and explain their use:

_____ _____

Are you restricted from performing any activities or functions due to any medical condtion? Yes ___ No ___

If yes, please explain:_____

Are you presently wearing any orthotic support or brace? Yes ___ No ___

If yes, please explain: _____

Please complete both pages, remember to sign at the bottom and return them to the front desk - Thank You!

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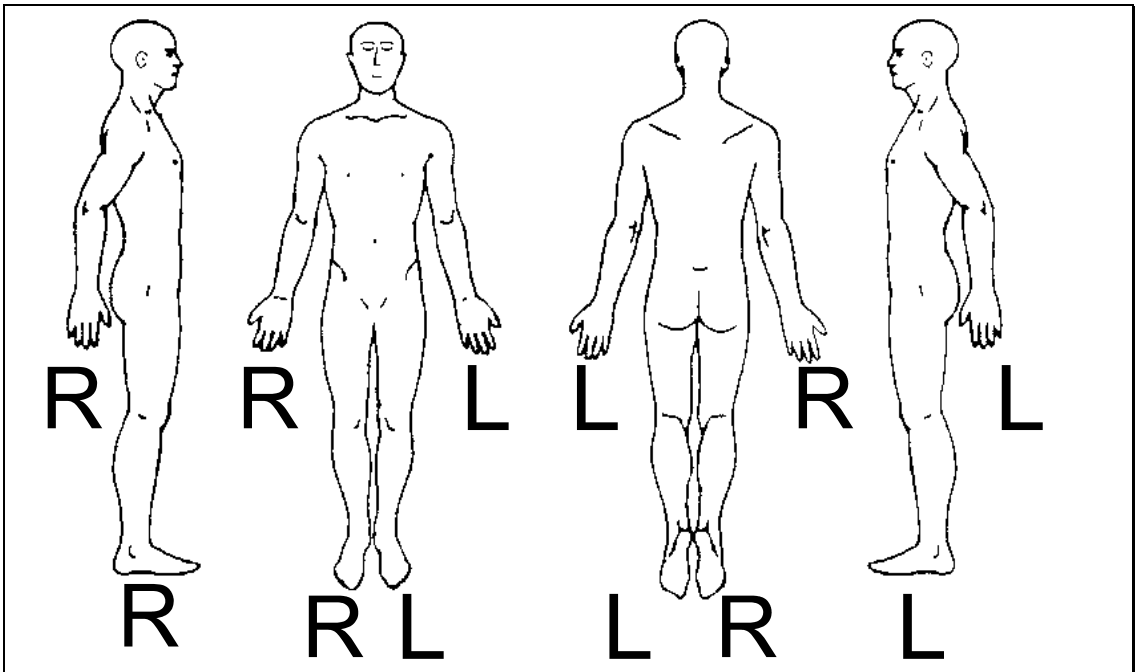
If you are experiencing any pain, please show us where by marking it on the figures below:



On a scale of 1 - 10, with 1 being "no pain" and 10 being "excruciating pain" please circle the number that best represents the level of pain in your major area of concern at this time.

1 2 3 4 5 6 7 8 9 10

No Pain . . . . . .more pain. . . . . .Excruciating Pain

Florida Chiropractor invites you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Please inform the doctor whenever you have a concern about your chiropractic care. As with all health services, there may be risks involved with receiving treatment in this office. Please rest assured that all precautionary measures, diagnostic tests and relevant orthopedic testing will be requested and, with consent, performed to minimize this risk. By signing below you authorize treatment with the understanding of the information offered above and consent to allow necessary services and treatment according to the doctor's recommendations. Your signature also allows and authorizes Florida Chiropractor to release any information required to process any and all insurance claims. By signing below you understand that this is not a medical diagnostic center but a chiropractic office in which the main focus is to correct vertebral subluxations (spinal misalignments) in order that one's entire body can function better. Please complete:

Signature:_____ **Date:**_____

Please complete both pages, remember to sign at the bottom and return them to the front desk - Thank You!