Ybor City CHIROPRACTIC

1623 East 4th Avenue
Tampa, Florida 33605
813-248-2900

Patient Information

Date: _____

Patient Last Name: _____

First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Patient SSN: _____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone #: _____

Spouse's Name: _____

Birthdate: _____ SSN: _____

Occupation: _____

Spouse's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone #: _____

Whom may we thank for referring you? _____

Insurance

Name of Insured: _____

Relationship to Patient: _____

Birthdate: _____ SSN: _____

Insurance Company: _____

Group #: _____

Is patient covered by additional insurance? ☐ Y ☐ N

Name of Insured: _____

Relationship to Patient: _____

Birthdate: _____ SSN: _____

Insurance Company: _____

Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Relationship *Date*

Contact Details

Best Time to Contact you: _____

Check Preferred

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Email Address: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Accident Information

Is this condition due to an accident? ☐ Y ☐ N

Date of accident: _____

Type of accident: ☐ Auto ☐ Work ☐ Home

☐ Other (please explain): _____

To whom have you made a report of your accident?

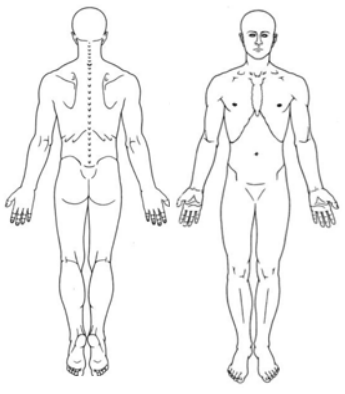
☐ Auto Insurance ☐ Employer

☐ Worker Compensation ☐ Other

Attorney Name (if applicable): _____

Patient Condition

Using the following symbols, mark on the body diagram: **X** = Pain **O** = Numbness **Z** = Tingling **/** = Other



Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Y ☐ N

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Sleep ☐ Work ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to preform (check all that apply): ☐ Sitting ☐ Walking ☐ Standing ☐ Bending ☐ Lying Down ☐ Other: _____

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other: _____

Name & address of other doctor(s) who have treated you for your condition: _____

_____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Mark "Yes" or "No" to indicate if you have ever had any of the following:

AIDS/HIV ☐ Y ☐ N	Diabetes ☐ Y ☐ N	Liver Disease ☐ Y ☐ N	Rheumatic Fever ☐ Y ☐ N
Alcoholism ☐ Y ☐ N	Emphysema ☐ Y ☐ N	Measles ☐ Y ☐ N	Scarlet Fever ☐ Y ☐ N
Allergy Shots ☐ Y ☐ N	Epilepsy ☐ Y ☐ N	Migraine Headaches ☐ Y ☐ N	Sexually Transmitted Disease ☐ Y ☐ N
Anemia ☐ Y ☐ N	Fractures ☐ Y ☐ N	Miscarriage ☐ Y ☐ N	
Anorexia ☐ Y ☐ N	Glaucoma ☐ Y ☐ N	Mononucleosis ☐ Y ☐ N	Stroke ☐ Y ☐ N
Appendicitis ☐ Y ☐ N	Goiter ☐ Y ☐ N	Multiple Sclerosis ☐ Y ☐ N	Suicide Attempt ☐ Y ☐ N
Asthma ☐ Y ☐ N	Gonorrhea ☐ Y ☐ N	Mumps ☐ Y ☐ N	Thyroid Problems ☐ Y ☐ N
Bleeding Disorders ☐ Y ☐ N	Gout ☐ Y ☐ N	Osteoporosis ☐ Y ☐ N	Tonsillitis ☐ Y ☐ N
Breast Lump ☐ Y ☐ N	Heart Disease ☐ Y ☐ N	Pacemaker ☐ Y ☐ N	Tuberculosis ☐ Y ☐ N
Bronchitis ☐ Y ☐ N	Hepatitis ☐ Y ☐ N	Parkinson's Disease ☐ Y ☐ N	Tumors, Growths ☐ Y ☐ N
Bulimia ☐ Y ☐ N	Hernia ☐ Y ☐ N	Pinched Nerve ☐ Y ☐ N	Typhoid Fever ☐ Y ☐ N
Cancer ☐ Y ☐ N	Herniated Disk ☐ Y ☐ N	Pneumonia ☐ Y ☐ N	Ulcers ☐ Y ☐ N
Cataracts ☐ Y ☐ N	Herpes ☐ Y ☐ N	Polio ☐ Y ☐ N	Vaginal Infections ☐ Y ☐ N
Chemical Dependency ☐ Y ☐ N	High Blood Pressure ☐ Y ☐ N	Prostate Problem ☐ Y ☐ N	Whooping Cough ☐ Y ☐ N
	High Cholesterol ☐ Y ☐ N	Psychiatric Care ☐ Y ☐ N	Other _____
Chicken Pox ☐ Y ☐ N	Kidney Disease ☐ Y ☐ N	Rheumatoid Arthritis ☐ Y ☐ N	_____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activities

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Habits

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Are you pregnant? ☐ Y ☐ N Due Date:

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name		
Pharmacy Number		