NAME: (first)_____(initial)_____(last)_____ DATE:_____

DATE OF BIRTH:_____ Home phone:_____ Day phone:_____ Cell:_____

Address:_____

Email:_____(Used for appointment reminders)

City:_____State:_____ Zip:_____ Marital status:_____

Number of Children:_____ Spouse's name (parents' names if minor):_____

Occupation (if retired, former occupation):_____ Employer:_____

Nearest relative:_____ Phone:_____

How did you find out about our office?_____

Family medical physician:_____ City:_____Date of last exam:_____

Reasons for your visit to our office:

1) _____ How long have you had symptoms?_____

2) _____ How long have you had symptoms? _____

3) _____ How long have you had symptoms? _____

Remarks:_____

_____

Check if accident related: _____Auto _____Work _____Home _____Athletics _____Other:_____

--Have you see a chiropractor before? ___yes ___no

Other health care providers seen for above complaints:

Name:_____Dates:_____Diagnosis:_____

Treatment:_____Result:_____

Name:_____Dates:_____Diagnosis:_____

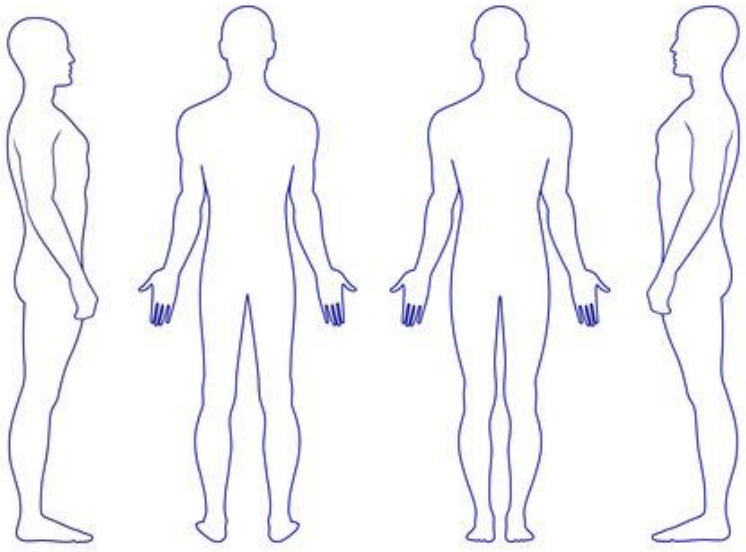
Treatment:_____Result:_____

Name:_____Dates:_____Diagnosis:_____

Treatment:_____Result:_____

Pain drawings- mark your pain areas on the diagrams as indicated:

Xxxx = pain
//////// = tingling/needles
ooooo = burning
+++++ = numbness
wwww = weak



Surgeries: (please list all)

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

Medications:

1_____/reason:_____ 2 _____/reason:_____

3_____/reason:_____ 4 _____/reason:_____

5_____/reason:_____ 6 _____/reason:_____

List serious accidents/falls with dates:_____

_____

_____

Check the following conditions you have or had:

❑ scarlet fever ❑ rheumatic fever ❑ polio ❑ tuberculosis ❑ whooping cough ❑ anemia

❑ measles ❑ mumps ❑ chicken pox ❑ diabetes ❑ heart attack ❑ cancer:_____

❑ pleurisy ❑ alcoholism ❑ chronic infection:_____

Carbonated drinks: occasional/none ❑frequent **Smoke?** _____ packs per day **Alcohol:** ____drinks per (day)(week)(month)

Recreational drug use? What?_____ Frequency?_____

REVIEW OF SYSTEMS: ***CIRCLE*** current problems, put a √ ***CHECK*** next to former problems

Neck stiffness or pain	fever	poor or excessive appetite	chronic cough
Arm/wrist/hand pain	chills	burping or gas	cough with mucous or phlegm
Headache	sweats	nausea	chest pain
Low back pain	fainting	vomiting	difficult breathing
Other back pain	dizziness	abdominal pain	asthma or emphysema
Arthritis	convulsions/seizures	abdominal bloating	----------
Irritability	loss of sleep	constipation	vision problem
Swollen joints	fatigue	diarrhea	hearing problem
Tail bone pain	nervousness	colitis/irritable bowel	abnormal sense of touch
Foot problems	loss of weight	heartburn or reflux	abnormal sense of taste/smell
Pain by shoulder blades	numbness/tingling	hemorrhoids	eye pain
Shoulder joint pain	allergy	liver problem	earache
Hernia	neuralgia	gall bladder problem	ear noises
Spinal curvature (scoliosis)		jaundice	sore throat
----------	----------	diverticulosis/itis	hoarseness
Abnormal heart rate	Skin problem	----------	hayfever
High blood pressure	itching	frequent urination	----------
Low blood pressure	bruises easily	painful urination	FEMALES:
Pain over heart	dry skin	blood or pus in urine	painful menstrual periods
Swelling of ankles	boils	bladder infection	excessive flow
Poor circulation	painful varicose veins	kidney infection or stones	irregular cycle
Stroke	hives or skin allergy	bed wetting	cramps or back pain
Other heart condition	shingles	inability to control urine	hot flashes
		Prostate trouble	previous miscarriage
			Last menstrual period_____

I understand that I am personally responsible for payment of all services rendered. This includes charges not covered by third party insurance. I authorize submission of any protected health information needed for obtaining reimbursement from insurance carriers. I voluntarily consent to receive treatment from the physicians and staff of GentleBay Sarasota Chiropractic as explained to me by the physicians and/or their designated chiropractic assistants.

Patient's signature:_____ Date: _____

Parent or Legal Guardian's signature authorizing care: _____ Date:_____