Personal and Family Health History

Name:	Date:
Address:	Referred By:
City: State: Zip:	Occupation:
Phone: (H) (C) (W)	Employer:
E-mail:	Retired?: Y N
Date of Birth:	Student? Y N
Social Security #:	Marital Status:
Out of Town Address:	Spouses Name:
	Spouses Occupation:
What do you prefer to be called?	Emergency Contact Name:
	Emergency Contact Number:

Current Health Condition

Reason for your visit:

Date problem started:

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is your condition related to an accident? Y N Type of Accident? ☐ Auto ☐ Work ☐ Home ☐ Sports ☐ Other

What activities lessen your condition / pain?

Is this condition interfering with work? Sleep? Taking care of yourself?

Is this condition getting progressively worse?

How serious do you think this problem is? (0 = No Problem 10 = The Worst) 0 1 2 3 4 5 6 7 8 9 10

Describe the different types of remedies you have tried?

How frustrated are you? (0 = Not at all 10 = Very frustrated) 0 1 2 3 4 5 6 7 8 9 10

Females – Are you pregnant? ☐ Yes ☐ No ☐ Unknown

Other Symptoms (Have you EVER had any of the following?)

☐ Sleeping Problems	☐ Shortness of Breath	☐ Fainting	☐ Stomach Upset	☐ Acid Indigestion/Heartburn
☐ Nervousness	☐ Fatigue	☐ Cold Sweats	☐ Constipation	
☐ Tension	☐ Depression	☐ Loss of Smell	☐ Loss of Balance	
☐ Irritability	☐ Light Bothers Eyes	☐ Loss of Taste	☐ Buzzing in Ear	
☐ Chest Pains	☐ Loss of Memory	☐ Diarrhea	☐ Irregular Heart Beat	
☐ Dizziness	☐ Ears Ring	☐ Feet Cold	☐ Hot Flashes	
☐ Face Flushed	☐ Fever	☐ Hands Cold	☐ Muscle Cramps "Charlie Horse"	

What medications are you taking and how long?

What surgery have you had and when?

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Have you seen a Chiropractor in the past? ☐ Yes ☐ No If yes, how long ago?

When was the last time you were seen by your Medical Doctor?

What was the reason?

Circle all that Apply – Current Health Habits:

Smoke?	Y	How Much?
Drink Alcohol?	Y	How Much?
Have you ever been in a car accident?	Y	When?
Do you take vitamins/supplements?	Y	What?
Do you exercise regularly?	Y	How Often?
Do you have a history of back problems?	Y	Explain:
Do you have a history of headaches?	Y	Explain:

Children and Ages:

Previous Chiropractic Care?

Name:	Age:	Y	N	Reason
Name:	Age:	Y	N	Reason
Name:	Age:	Y	N	Reason
Name:	Age:	Y	N	Reason

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Upon the completion of your first visit, you will receive a follow up Chiropractic Report of Finding. During this visit the Doctor will decide if you qualify for care or not and what care is appropriate for your particular problem.

As a result of my chiropractic care, I would like to:
(Please check all that apply)

☐ Feel Better Quickly ☐ Have a healthier body by keeping my nerve system healthy

☐ Have a healthier spine ☐ Live a healthier lifestyle

Symptom Survey

Head: (Circle as many as apply)
A) Headache 1-Mild 2-Moderate 3-Severe
How often: (1 2 3 4 5 6) Per (Day / Week / Month)
Are They: 1-Sharp 2-Dull
Are They: 1-Constant 2-Intermittent
Where located: 1-Back of Head 2-Forehead
3-Temples 4-Right side
5-Left side 6-Behind eyes
B) Jaw Pain 1-Mild 2-Moderate 3-Severe

Symptom Survey

Neck: (Circle as many as apply)
A) Pain 1-left side 2-right side 3-both
Pain level 1-mild 2-moderate 3-severe
Pain increased by: 1-Forward movement
2-Backward movement
3-Rotate head left
4-Rotate head right
5-Bend neck left
6-Bend neck right
B) Stiffness
C) Muscle Spasm
D) Grinding/Grating Sounds

Fliss Laser and Chiropractic

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Symptom Survey

Shoulders: (Circle as many as apply)			
A) Pain in joint	1-left	2-right	3-both
B) Pain across shoulder	1-left	2-right	3-both
C) Limitation of movement	1-left	2-right	3-both
D) Tension	1-left	2-right	3-both
Arms: (Circle as many as apply)			
A) Pain in upper arm	1-left	2-right	3-both
B) Pain in elbow	1-left	2-right	3-both
C) Pain in forearm	1-left	2-right	3-both
D) Pins & needles (arm)	1-left	2-right	3-both
E) Pins & needles (forearm)	1-left	2-right	3-both
F) Numbness in arm	1-left	2-right	3-both
G) Numbness in forearm	1-left	2-right	3-both
Hands: (Circle as many as apply)			
A) Pain in wrist	1-left	2-right	3-both
B) Pain in hand	1-left	2-right	3-both
C) Pins & needles in hand	1-left	2-right	3-both
D) Numbness in hand	1-left	2-right	3-both
Mid back: (Circle as many as apply)			
A) Pain	1-left	2-right	3-both
Pain level:	1-mild	2-moderate	3-severe
Pain type:	1-mild	2-moderate	3-severe
B) Muscle spasm	1-left	2-right	3-both
Chest: (Circle as many as apply)			
A) Deep chest pain	1-left	2-right	3-both
Pain level:	1-mild	2-moderate	3-severe
B) Pain around ribs	1-left	2-right	3-both

Symptom Survey

Lower back: (Circle as many as apply)			
A) Upper lumbar pain	1-left	2-right	3-both
B) Lower lumbar pain	1-left	2-right	3-both
C) Sacroiliac pain	1-left	2-right	3-both
D) Muscle Spasm	1-left	2-right	3-both
Pain level:	1-mild	2-moderate	3-severe
Hips and legs: (Circle as many as apply)			
A) Pain in buttocks	1-left	2-right	3-both
Pain level:	1-mild	2-moderate	3-severe
B) Pain in hip joint	1-left	2-right	3-both
Pain level:	1-mild	2-moderate	3-severe
C) Pain down leg	1-left	2-right	3-both
Location:	1-front	2-back	3-side
Pain Radiates to:	1-knee	2-calf	3-foot
D) Numbness down leg	1-left	2-right	3-both
Location:	1-front	2-back	3-side
E) Pins & needles (leg)	1-left	2-right	3-both
Location:	1-front	2-back	3-side
F) Knee pain	1-left	2-right	3-both
G) Leg cramps	1-left	2-right	3-both
Feet: (Circle as many as apply)			
A) Ankle Pain	1-left	2-right	3-both
B) Swollen ankle	1-left	2-right	3-both
C) Foot pain	1-left	2-right	3-both
D) Numbness of feet	1-left	2-right	3-both
E) Swollen Feet	1-left	2-right	3-both
F) Cramps	1-left	2-right	3-both

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____ (name of practice) to release a copy of my patient records or x-rays containing protected health information to Fliss Chiropractic Clinic. This authorization is given pursuant to Florida Statute 4456.057 and HIPAA regulations. I understand that Florida Statue 456.057 (10) 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's Legal Representative's Signature: _____

Patients Date of Birth: _____ Date: _____

Specific description of information to be disclosed: _____

_____

Please mail or fax all records requested to:

FAX: 941-351-3639

Fliss Chiropractic Clinic
7425 North Tamiami Trail
Sarasota, FL 34243

Personal and Family Health History

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on the pages of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I understand that if I am accepted as a patient, I am authorizing the physician to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon request.

Method of Payment ☐ Check ☐ Cash ☐ Credit/Debit Card

Patient's Signature: _____ Date: _____

Guardian or Parent's Signature: _____ Date: _____
(If patient is under age 18)

FOR DOCTOR'S USE BELOW

CASE HISTORY

Name: _____ Date: _____

Height: Weight: BP: Temperature: Pulse: IHR: Y N

Primary reason for visit:
DESCRIPTION OF COMPLAINT:
Location:
Type:
Onset:
Duration:
Frequency:
Mode Onset:
Radiation:
Better:
Worse:
Treatment:
PAST HISTORY:
Illness:
Accident:
Surgery:
HISTORIES:
Family:
Marital:
Occupation:
Social Habits:
OTHER SYMPTOMS:
Head and Neck:
Heart and Lungs:
Digestive/Stomach/Gall Bladder:
Nerve, Muscle, Joint:
Other: