

# Patient Information Form

## Patient Information

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ # of Children: \_\_\_\_\_  
SSN: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Would you like text message and/or email reminders of your appointments? \_\_\_\_\_  
If you would like text message reminders, please write your mobile carrier \_\_\_\_\_  
Patient Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Emergency Contact Information

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Insurance Information

Do you have insurance? \_\_\_\_\_  
Would you like us to bill your insurance for you? \_\_\_\_\_  
If yes to both questions, please provide us your card to take a copy of.

## Referral/Purpose

How were you referred? \_\_\_\_\_  
Purpose of this appointment \_\_\_\_\_  
Have you ever had same/similar condition? Describe: \_\_\_\_\_  
\_\_\_\_\_  
Days lost from work? \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to Palm Coast Sports Medicine. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform the office.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Case History

### Review or Systems

Do you have skin, hair, or nail problems? \_\_\_\_\_

Do you have mouth and/or throat problems? \_\_\_\_\_

Do you have nose and/or sinus problems? \_\_\_\_\_

Do you have ear problems? \_\_\_\_\_

Do you have eye problems? \_\_\_\_\_

Do you have chest or lung (breathing) problems? \_\_\_\_\_

Do you Smoke? \_\_\_\_\_ Cigarettes per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Do you have heart and/or blood vessel problems? \_\_\_\_\_

Do you have blood or lymph node problems? \_\_\_\_\_

Do you have digestive problems? \_\_\_\_\_

Do you have genital problems? (Ex. Prostate, testicular, vaginal)? \_\_\_\_\_

Do you have urinary (including kidney or bladder) problems? \_\_\_\_\_

Do you have any gland and/or hormone problems? \_\_\_\_\_

Do you have allergy or immunity problems? \_\_\_\_\_

Do you have any muscle, tendon, or ligament problems? \_\_\_\_\_

Do you have any bone or joint diseases (Ex. osteoporosis, arthritis)? \_\_\_\_\_

Do you have any nervous system, disease and/or mental health problems? \_\_\_\_\_

### Females Only

Have you had menstrual problems? \_\_\_\_\_

Have you ever taken birth control? \_\_\_\_\_

Is there any chance you could be currently pregnant? \_\_\_\_\_

Do you have any breast problems? \_\_\_\_\_

### Past History

List any diseases that you have had in the past, including childhood disease: \_\_\_\_\_

Tell us if you have ever been diagnosed as having a particular condition such as diabetes, AIDS, ect.: \_\_\_\_\_

Have you suffered any physical injuries, such as falls or blows, auto accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken, or cracked bones? \_\_\_\_\_

List any surgeries you have had. (Including appendix, tonsils, ear tubes, and wisdom teeth): \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been hospitalized for any reason other than surgery? \_\_\_\_\_

Medications: Please list all prescriptions/non-prescriptions medication you are taking on a regular and/or occasional basis \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Social History

In what position do you usually sleep and how well? \_\_\_\_\_  
Do you exercise on a regular basis? \_\_\_\_\_  
How do you spend your spare time? \_\_\_\_\_  
Do you use: Caffeine? \_\_\_\_\_ Tobacco? \_\_\_\_\_ Nicotine? \_\_\_\_\_ Recreation drugs? \_\_\_\_\_ Alcohol? \_\_\_\_\_  
Please describe your work type: Physical labor? \_\_\_\_\_ Driver? \_\_\_\_\_  
Clerical? \_\_\_\_\_ Factory? \_\_\_\_\_ Homemaker? \_\_\_\_\_  
Describe your physical demands: Heavy? \_\_\_\_\_ Moderate? \_\_\_\_\_ Mild? \_\_\_\_\_ Sedentary? \_\_\_\_\_  
Please describe your work stress level: High? \_\_\_\_\_ Medium? \_\_\_\_\_ Low? \_\_\_\_\_  
Your diet is: Balanced: \_\_\_\_\_ Fair: \_\_\_\_\_ Poor: \_\_\_\_\_ Excessive: \_\_\_\_\_ Rstrctd: \_\_\_\_\_

### Family History

Are there any diseases or conditions that are common among your family members? \_\_\_\_\_  
\_\_\_\_\_

### Additional Questions

Do you have a problem with recurring headaches? \_\_\_\_\_  
Are you losing weight without trying? \_\_\_\_\_  
Does your pain wake you up at night? \_\_\_\_\_  
Have you had a sore throat that doesn't heal? \_\_\_\_\_  
Do you have indigestion or difficulty swallowing? \_\_\_\_\_  
Have you had an obvious change in a wart or mole? \_\_\_\_\_  
Do you have a nagging cough or hoarseness? \_\_\_\_\_  
In the space below, please explain or give additional details regarding the information you have given above.  
Also, if there is any information about your health history that was not requested, please fill it in below: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Patient Health History

**Have you ever (at any time) experienced any of the following?**

|                                    |  |  |                                       |   |   |
|------------------------------------|--|--|---------------------------------------|---|---|
| Difficulty urinating               |  |  | Claustrophobia (fear of small spaces) | Y | N |
| Loss of bladder control            |  |  | Spinal surgery                        | Y | N |
| Loss of bowel control              |  |  | Common cold/flu                       | Y | N |
| Temporary loss of vision (one eye) |  |  | Carotid artery surgery                | Y | N |
| Blood in urine                     |  |  | Breast removal                        | Y | N |

**Have you ever been diagnosed with or told you have one of the following?**

|                            |   |   |                               |   |   |
|----------------------------|---|---|-------------------------------|---|---|
| Detached retina            | Y | N | Hardening of the arteries     | Y | N |
| Stroke                     | Y | N | Rheumatoid arthritis          | Y | N |
| Slipped disc               | Y | N | Fractured/broken vertebra     | Y | N |
| Herniated disc             | Y | N | Bleeding disorders            | Y | N |
| Osteoporosis               | Y | N | High blood pressure           | Y | N |
| Drop attacks               | Y | N | Blood in stool                | Y | N |
| TIAs (pin or mini strokes) | Y | N | Cancer                        | Y | N |
| Kidney disease             | Y | N | Prostate Disease              | Y | N |
| AIDS                       | Y | N | Partial or complete paralysis | Y | N |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Patient Health History Continued

**Do you currently have or could be, any of the following?**

**In the past 14 days, have you experienced any of the following?**

|                                          |   |   |                                      |   |   |
|------------------------------------------|---|---|--------------------------------------|---|---|
| Pregnant                                 | Y | N | Nausea                               | Y | N |
| Taking birth control pills               | Y | N | Vomiting                             | Y | N |
| Receiving hormone therapy (male)(female) | Y | N | Vertigo (spinning)                   | Y | N |
| Receiving chemotherapy                   | Y | N | Difficulty walking                   | Y | N |
| Receiving radiation therapy              | Y | N | Uncoordinated                        | Y | N |
| Taking blood thinners                    | Y | N | Numbness or other sensory complaints | Y | N |
| Head Trauma                              | Y | N | Abnormal period                      | Y | N |
| A heavy smoker (1 or more packs a day)   | Y | N | Loss of consciousness                | Y | N |
| Surgical/medical implanted devices:      | Y | N | Double vision                        | Y | N |
| Aortic clips                             | Y | N | Blurred vision                       | Y | N |
| Brain clips                              | Y | N | Tinnitus (ringing in ears)           | Y | N |
| Artificial heart valves                  | Y | N | Speech problems                      | Y | N |
| Rods, pins, screws                       | Y | N | Clumsiness                           | Y | N |
| IUD                                      | Y | N | Memory loss                          | Y | N |
| Surgical clips/wires                     | Y | N | Travel by car/truck                  | Y | N |
| Shunt                                    | Y | N | Personality changes                  | Y | N |
| Neurostimulator                          | Y | N | Fever                                | Y | N |
| Dentures                                 | Y | N | Recurrent headaches                  | Y | N |
| Pacemaker                                | Y | N | Diarrhea                             | Y | N |
| Hearing aid                              | Y | N | Use a tanning booth/bed              | Y | N |
| Insulin pump                             | Y | N | Skin rash/infection                  | Y | N |
| Joint replacement                        | Y | N | A major fall                         | Y | N |
| Cochlear implants (ear)                  | Y | N | A minor fall                         | Y | N |
| Other implanted devices:                 | Y | N | An auto accident                     | Y | N |
| Metal fragments                          | Y | N | A work injury                        | Y | N |
| Bullets/shrapnel                         | Y | N | Loss of strength                     | Y | N |
| Body piercing                            | Y | N | Pain during bowel movements          | Y | N |

**Do you currently have any of the following?**

### Integument System

### Endocrine System

|                       |   |   |                      |   |   |
|-----------------------|---|---|----------------------|---|---|
| Skin rash             | Y | N | Hormone problems     | Y | N |
| Skin lesion           | Y | N | Hot flashes          | Y | N |
| Changes in skin color | Y | N | Thyroid problems     | Y | N |
| Itching (pruritus)    | Y | N | Hormone therapy      | Y | N |
| Hair changes          | Y | N | Growth abnormalities | Y | N |
| Nail changes          | Y | N | Metabolism changes   | Y | N |

### Digestive System

|                |   |   |                      |   |   |
|----------------|---|---|----------------------|---|---|
| Abdominal pain | Y | N | Hormone problems     | Y | N |
| Nausea         | Y | N | Jaundice             | Y | N |
| Vomiting       | Y | N | Abdominal distention | Y | N |
| Constipation   | Y | N | Cramping             | Y | N |
| Diarrhea       | Y | N | Lump/mass            | Y | N |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Cardiovascular System

|                     |   |   |                       |   |   |
|---------------------|---|---|-----------------------|---|---|
| Chest pain          | Y | N | Changes in skin color | Y | N |
| Irregular heartbeat | Y | N | Stroke (full of pain) | Y | N |
| Shortness of breath | Y | N | Dizziness             | Y | N |
| Fainting            | Y | N | Cool hands or feet    | Y | N |
| Fatigue             | Y | N | Varicose veins        | Y | N |
| Swelling of legs    | Y | N | Mitral valve problems | Y | N |

## Pulmonary System

## Musculoskeletal System

|                      |   |   |                        |   |   |
|----------------------|---|---|------------------------|---|---|
| Coughing             | Y | N | Stiffness              | Y | N |
| Phlegm/expectorant   | Y | N | Popping noises         | Y | N |
| Coughing up blood    | Y | N | Joint pain             | Y | N |
| Shortness of breath  | Y | N | Weakness               | Y | N |
| Wheezing             | Y | N | Limitation of movement | Y | N |
| Blue skin (cyanosis) | Y | N | Extremity deformities  | Y | N |
| Chest pain           | Y | N | Difficulty walking     | Y | N |

## Nervous System

|                       |   |   |                       |   |   |
|-----------------------|---|---|-----------------------|---|---|
| Partial paralysis     | Y | N | Lack of coordination  | Y | N |
| Complete paralysis    | Y | N | Psychiatric disorders | Y | N |
| Headache              | Y | N | Speech abnormalities  | Y | N |
| Are you right-handed? | Y | N | Visual disturbances   | Y | N |
| Loss of consciousness | Y | N | Are you left-handed?  | Y | N |
| Dizziness             | Y | N | Gait disorders        | Y | N |
| Memory loss           | Y | N | Tremors               | Y | N |
| Numbness              | Y | N | Tics (spasms)         | Y | N |
| Weakness              | Y | N | Sensory changes       | Y | N |
| Depression            | Y | N | Mood changes          | Y | N |

## Genital/Urinary System

## Special Senses

|                                |   |   |                                  |   |   |
|--------------------------------|---|---|----------------------------------|---|---|
| Pain during urination          | Y | N | Visual problems                  | Y | N |
| Changes in urine flow          | Y | N | Hearing loss                     | Y | N |
| Lump or mass in groin          | Y | N | Loss of balance                  | Y | N |
| Kidney stones                  | Y | N | Loss of taste                    | Y | N |
| Chronic bladder infections     | Y | N | Loss of smell                    | Y | N |
| Genital itching                | Y | N | Loss of touch sensation          | Y | N |
| Changes in urination frequency | Y | N | Temporary vision loss in one eye | Y | N |
| Changes in urine color         | Y | N |                                  |   |   |

## Male Reproductive System

## Female Reproductive System

|                 |   |   |                           |   |   |
|-----------------|---|---|---------------------------|---|---|
| Testicular pain | Y | N | Abnormal vaginal bleeding | Y | N |
| Prostate pain   | Y | N | Painful menstruation      | Y | N |
| Infertility     | Y | N | Breast lump/mass          | Y | N |
| Impotence       | Y | N | Vaginal discharge/itching | Y | N |
| Discharge       | Y | N | Nipple Discharge          | Y | N |
| Lump or mass    | Y | N | Infertility               | Y | N |
|                 |   |   | Abnormal periods          | Y | N |
|                 |   |   | Male pattern baldness     | Y | N |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Head/Neck Region

|                    |   |   |                   |   |   |
|--------------------|---|---|-------------------|---|---|
| Headaches          | Y | N | Ring in ears      | Y | N |
| Neck stiffness     | Y | N | Ear pain          | Y | N |
| Neck lump/pain     | Y | N | Ear discharge     | Y | N |
| Eye pain           | Y | N | Ear itching       | Y | N |
| Eye redness        | Y | N | Nasal discharge   | Y | N |
| Eye discharge      | Y | N | Sinus trouble     | Y | N |
| Double vision      | Y | N | Bad breath        | Y | N |
| Dry eyes           | Y | N | Nasal obstruction | Y | N |
| Excessive tearing  | Y | N | Snoring           | Y | N |
| Spinning sensation | Y | N |                   |   |   |

## Blood, Lymphatic, Immunology, Allergy

|                   |   |   |                   |   |   |
|-------------------|---|---|-------------------|---|---|
| Anemia            | Y | N | Frequent illness  | Y | N |
| Iron deficiency   | Y | N | Immunity problems | Y | N |
| Clotting problems | Y | N | Allergies         | Y | N |
| Bruise easily     | Y | N | Take allergy shot | Y | N |
| Swollen lymph     | Y | N |                   |   |   |

## Current Treating Physicians

Primary Care Physicians: \_\_\_\_\_ Phone #: \_\_\_\_\_  
OB/GYN: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Any Additional Information

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## Credit Guarantee Insurance Assignment & Personal Balance

**Insurance Assignment:** Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

**Filing Procedure:** Claims for initial services are submitted within 48 hours after your visit. On day 90, if your insurance company had not paid the bill, we will change your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you. Please keep in mind this office will not bill your card without first trying to contact you.

**Personal Balance:** Estimated personal portions are paid at the time of service.

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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