Destination Spine Care

Health and History Information

Personal

Name:____Gender: M or F

Home Address: ____

City:_________________State:________________Zip:_________________________

Cell Phone:_____________________ Home Phone: ______________________________

Birthdate: _____________________Age:_____ SS#________________________

Employer:________________________________ Work Phone: ___________________

Marital Status: ___________________ Spouse's Name: _____________________

Emergency Contact:_____________________ Phone Number:_______________

Family Physician:_________________________ Phone Number:___________________

How did you hear about our office? ____

EMAIL ADDRESS: ____

Insurance Information

Insurance Company____

Insured Name: ____

Policy Number:____

Group Number:____

*****For motor vehicle accidents we MUST have YOUR insurance claim number and adjuster information (Florida is a no fault state) *****

Claim #______________________Adjuster name__________________Phone________

Reason for Visit

Have you ever been to a Chiropractor? YES Or NO

If yes, what was the reason? ______________________________________

The reason for THIS visit? :

____

____

When did this condition begin?:_______________________________________ Is this condition due to an injury or accident? : ________________if yes, please Explain:_

____ Is this condition getting worse? YES or NO Constant OR Comes and Goes

Is this condition interfering with your: Work Sleep Daily Routine

Have you had this or a similar condition in the past? YES or NO

If yes, when? ____

Have you been treated by a medical doctor for this condition? YES or NO

If yes, when?______________________Were X-Rays taken? YES or NO

Health History

Medications you are currently taking:____

____

Previous surgeries____

Allergies?____

Do you smoke? ________ if yes, how much? ______________ How long?__________

What is the age of your mattress?_____ Is it comfortable?__________________

Do you wear: Heel lifts? _____ Arch supports? _____ Inner soles? __________

What is your health philosophy? (What do you think makes you healthy?)________

____

Do you want temporary relief or corrective care? ___________________________

What is your current weight?______ Height?_____

Are you happy at your current weight?______ Are you low in energy?____

Do you skip meals?_____ Are you taking any vitamins/supplements? If so, what?

____

For Women: Are you taking birth control?___________________

Are you pregnant?_________________ If yes, how long?___________

Are you nursing? _____________________________

____

Family History

Have you or any immediate family members ever had any of the following disease/medical conditions?

Condition	You	Family/Relation	Condition	You	Family/Relation
Heart attack/Stroke			Congenital heart condition		
Alcohol/Drug Abuse			HIV/Aids		
Neck pain/TMJ			High/Low blood pressure		
Headaches			Fainting/Seizures		
Diabetes			Tuberculosis		
Back pain			Heart condition		
Venereal Disease			Shingles		
Emphysema/COPD			Glaucoma		
Psychiatric Problems			Kidney Problems		
Sinus Problems			Difficulty Breathing		
Artificial Bones/Joints			Hepatitis		
Cancer			Anemia		
Rheumatic Fever			Ulcers/Colitis		
Asthma:			Arthritis		

- We invite you to discuss any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If the account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for the balance and any expenses incurred in collecting your account.
- I authorize Destination Spine Care to perform any necessary tests and/or treatments. I also authorize Destination Spine Care to release any information to my insurance carrier and/or family physician.
- I understand the above information and guarantee this form was completed correctly and understand it is my responsibility to inform this office of any changes in my medical condition.

PATIENT SIGNATURE:____

DATE:____