Core Chiropractic and Wellness, L.L.C.
4900 U.S. Highway 19
New Port Richey, FL 34652
P:727-807-7020
F:727-807-7021

Chart#_____

PATIENT INFORMATION

Full Name:_____ Birth Date:_____ Gender: M / F

Address:_____City:_____State:____Zip:_____

Email address :_____

Home Phone:_____ Cell:_____Cell Provider:_____
Work Phone:_____ SS#_____-___-_____

Marital Status: S M W D Sep Spouse Name:_____
Are You A Minor Y / N Are You A Student Y / N

Your Employer:_____Your Occupation:_____
Employer Address:_____

Spouse Employer:_____Spouse Occupation:_____

Insurance (Please allow our staff to photocopy your health insurance cards)

Name of Primary Insurance:_____ID#:_____

Name of Insured if Different from Patient:_____Date of Birth:_____

Relationship to Patient:_____

Name of Seconday Insurance:_____ID#:_____

Please Tell Us How You Were Referred Here:_____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- There will be a $25.00 charge for any Returned/NSF checks and missed appointments.
- We utilize Capital Accounts for any Delinquencies.

Patient's Signature:_____ Date:_____
Spouse / Guardian's Signature:_____ Date:_____
(Authorization expires 3 years from date above)

Core Chiropractic and Wellness, L.L.C.
4900 U.S. Highway 19
New Port Richey, FL 34652
(727)-807-7020

Patient DOB: _____
Patient MR#: _____

CASE HISTORY

Full Name:_____Date:_____
History of Present Injury/Illness
Please list below complaint(s) you have in order of importance. Also the length of time you have had these complaint(s).

1. **_____How long?_____**
2. **_____How long?_____**
3. **_____How long?_____**

Is your condition(s) related to an accident: __YES __NO
Date of accident:_____Type of accident: __Auto __Work Related__Other_____
Have you had any previous Trauma or Accidents? When _____

When is your condition most severe? _____
When is your condition least severe? _____
What makes your condition feel worse? _____
What makes your condition feel better? _____

Have you seen any other health care provider for you present condition? __YES __NO
Who? _____
Current Medications _____ ( ) None
Allergies _____ ( ) None

Are you or could you be pregnant? __YES __NO 1st day of last menstrual period _____

Do you use __Alcohol __Tobacco __Other Substances: _____ ( ) None
Water Intake_____oz Coffee_____oz Tea_____oz Soda Reg/Diet____oz

Are you experiencing or do you have any of the following?

__ A sore that won't heal	**__ Difficulty swallowing**	**__ Persistent cough/hoarseness**
__ Any bleeding/discharge	**__ Lump/thickening anywhere**	**__ Wart/mole changes**
__ Bladder/bowel problems	**__ Night pain**	**__ Weight loss without trying**
		__ None of the above

<u>Review of Systems</u>
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?
Neuromusculoskeletal System

__ Anxiety	**__ Facial drooping**	**__ Loss of balance**	**__ Seizures**
__ Atrophy	**__ Headache**	**__ Memory loss**	**__ Sensory changes**
__ Concussion	**__ Joint deformity**	**__ Mood swings**	**__ Speech problems**
__ Depression	**__ Joint locking**	**__ Muscle weakness**	**__ Stiffness**
__ Tremors	**__ Joint swelling**	**__ Numbness**	**__ Difficulty walking**
__ Dizziness	**__ Lack of coordination**	**__ Popping noises**	**__ Twitches**
__ Vision trouble	**__ Limited range of motion**	**__ Extremity deformity**	**__ Psychiatric disorders**
			__ None of the above

Cardiovascular System

__ Ankle Swelling	**__ Chest pain**	**__ Jaw pain**	**__ TIA**
__ Blood clots	**__ Dizziness**	**__ Known vascular disease**	**__ Previous stroke**
__ Fainting	**__ Carotid blockage**	**__ Mitral valve prolapse**	**__ Shortness of breath**
__ Hypertension	**__ Changes in skin color**	**__ Phlebitis**	**__ Varicose veins**
			__ None of the above

<u>Past History</u>
List any surgeries you have had (including appendix, tonsils, and wisdom teeth)
1. _____Date_____ 3. _____Date_____
2. _____Date_____ 4. _____Date_____

Have you ever been hospitalized in addition to surgeries? __YES __NO
If so, when and for what reason? _____
Have you ever been diagnosed with any condition? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__YES __NO _____
Do you have a family history of any disease? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__Yes __NO _____
Are you currently under a doctor's care for conditions other than ones you are seeking care for today?
__YES __NO _____

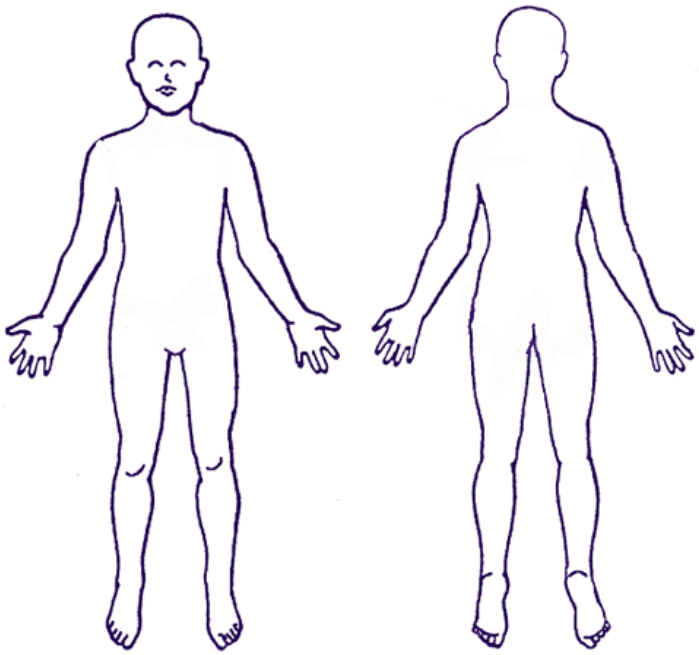
Core Chiropractic and Wellness, L.L.C.
4900 US Highway 19
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

PAIN DRAWING

Patient Name:_____ Date:_____

Please mark the areas where you feel the following sensations:

PAIN = P	BURNING = B
NUMBNESS = N	TINGLING = T
ACHE = A	SHARP = S



Indicate severity of pain by marking an X on the appropriate number:
(0 means no pain- 10 means worst possible pain)

How bad is your Neck Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Back Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Arm Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Leg Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Chart # _____
Date of Birth _____

Core Chiropractic and Wellness, L.L.C.
Phone: 727-807-7020
Fax: 727-807-7021

Consent to Treat Notice

I _____ hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Core Chiropractic and Wellness, L.L.C. This consent is extended to other licensed chiropractic physicians, chiropractic assistants, or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for m present condition(s) and for any future condition(s) for which I seek treatment.

_____ Vivian Robinson, D.C.
Patient or Representative Signature Doctor's Name

_____ _____
Witness's Signature Doctor's Signature

_____
Date