Welcome to Gulf Coast Rehabilitation and Wellness Center

Patient Information

Thank you for choosing Gulf Coast Rehabilitation and Wellness Center for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

Name: _____ *(please print clearly)*

Social Security#: _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Sex: ☐ *Female* ☐ *Male* *Birthdate:* _____ *Age:* _____

E-mail: _____

Home Phone: _____ *Cell:* _____ *Work:* _____

☐ *Married* ☐ *Widowed* ☐ *Single* ☐ *Minor* ☐ *Separated* ☐ *Divorced* ☐ *Partnered*

Patient Employer/School: _____ *Occupation:* _____

Employer Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Referred by whom/place? _____

Emergency contact: _____ *Phone:* _____

Insurance Co: _____

Phone: _____ *Group #* _____

Name of insured: _____ *Relationship to patient:* _____

Birthdate: _____ *Social Security#* _____

Employer: _____ *Phone:* _____

Have you had previous Chiropractic Treatment? ☐ *Yes* ☐ *No* *What?* _____

Reason for visit today: _____

When did you first notice the symptoms? _____

Are your present problems due to an injury or an accident? ☐ *No* ☐ *Yes*

If yes, type of accident? ☐ *Auto accident* ☐ *On the job* ☐ *Personal injury* ☐ *Other* _____

Has the accident been reported? ☐ *No* / ☐ *Yes:* ☐ *Insurance Co.* ☐ *Police* ☐ *Employer*

Is the condition getting progressively worse? _____

Which activities are difficult to perform? ☐ *Sitting* ☐ *Standing* ☐ *Walking* ☐ *Bending* ☐ *Lying down*

Type of pain: ☐ *Sharp* ☐ *Dull* ☐ *Throbbing* ☐ *Numbness* ☐ *Aching* ☐ *Shooting* ☐ *Burning*
☐ *Tingling* ☐ *Cramps* ☐ *Stiffness* ☐ *Swelling* ☐ *Other* ☐ *Constant Pain* ☐ *Comes and goes*

What treatment have you received for your condition? ☐ *Medication* ☐ *Surgery* ☐ *Physical Therapy*
☐ *Other* _____

HABITS

- ☐ *Smoking Packs/Day:*
- ☐ *Drinking Alcohol*
- ☐ *Coffee*

EXERCISE

- ☐ *None*
- ☐ *Moderate*
- ☐ *Daily*

Type _____
_____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother, # of ___	☐	☐	☐	☐
Sister, # of ____	☐	☐	☐	☐

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

☐ *541 Appendictis*	☐ *280 Anemia*	☐ *429.9 Heart Disease*	☐ *716 Arthritis*
☐ *480 Pneumonia*	☐ *055 Measles*	☐ *240 Goiter*	☐ *345 Epilepsy*
☐ *390 Rheumatic Fever*	☐ *072 Mumps*	☐ *487 Influenza*	☐ *319 Mental Disorder*
☐ *045 Polio*	☐ *052 Chicken Pox*	☐ *511 Pleurisy*	☐ *724.2 Lumbago*
☐ *011 Tuberculosis*	☐ *250 Diabetes*	☐ *305.0 Alcoholism*	☐ *690 Eczema*
☐ *033 Whooping Cough*	☐ *239 Cancer*	☐ *099 Veneral Disease*	☐ *044 HIV Positive*

Primary Care Doctor (MD/DO):

_____

Dates/reasons of last exams:

_____

Health History *Check only those conditions which are applicable:*

Please check the correct box for each item below. Check one box for each sign or symptom listed. ✓Never ✓Previously ✓Presently

Never	Previously	Presently	GENERAL SYMPTOMS		Never	Previously	Presently	GASTRO-INTESTINAL		Never	Previously	Presently	EYE/EAR/NOSE/THROAT		Never	Previously	Presently	RESPIRATORY	
☐	☐	☐	905.3	Allergies (what)	☐	☐	☐	787	Belching or Gas	☐	☐	☐	493.9	Asthma	☐	☐	☐	786.50	Chest Pain
					☐	☐	☐	789.0	Colon Trouble	☐	☐	☐	378.9	Crossed eyes	☐	☐	☐	786.2	Chronic cough
☐	☐	☐	491	Bronchitis	☐	☐	☐	564.0	Constipation	☐	☐	☐	389.9	Deafness	☐	☐	☐	786.09	Difficulty breathing
☐	☐	☐	780.9	Chills	☐	☐	☐	558.9	Diarrhea	☐	☐	☐	388.7	Earache	☐	☐	☐	786.3	Spitting blood
☐	☐	☐	780.3	Convulsions	☐	☐	☐	783.6	Excessive Hunger	☐	☐	☐	388.6	Ear discharge	☐	☐	☐	786.4	Spitting phlegm
☐	☐	☐	780.4	Dizziness	☐	☐	☐	575.9	Gall Bladder Trouble	☐	☐	☐	388.30	Ear noises					
☐	☐	☐	780.2	Fainting	☐	☐	☐	455.6	Hemorrhoids (piles)	☐	☐	☐	240.9	Enlarged thyroid	☐	☐	☐	**GENITO-URINARY**	
☐	☐	☐	780.7	Fatigue	☐	☐	☐	782.4	Jaundice	☐	☐	☐	460	Frequent colds	☐	☐	☐	788.3	Bet Wetting
☐	☐	☐	780.6	Fever	☐	☐	☐	794.8	Liver Trouble	☐	☐	☐	477.9	Hay fever	☐	☐	☐	599.7	Blood in Urine
☐	☐	☐	784.0	Headache	☐	☐	☐	787.0	Nausea	☐	☐	☐	784.49	Hoarseness	☐	☐	☐	788.4	Frequent Urination
☐	☐	☐	780.52	Loss of Sleep	☐	☐	☐	536.8	Pain over Stomach	☐	☐	☐	478.1	Nasal Obstruction	☐	☐	☐	788.3	Inability to Control
☐	☐	☐	783	Loss of Weight	☐	☐	☐	783.0	Poor Appetite	☐	☐	☐	784.7	Nose Bleeds					Urine
☐	☐	☐	799.2	Nervousness	☐	☐	☐	536.8	Poor Digestion	☐	☐	☐	379.91	Pain in Eyes	☐	☐	☐	590.9	Kidney Infection
☐	☐	☐	729.2	Neuralgia	☐	☐	☐	787.0	Vomiting	☐	☐	☐	368.9	Poor Vision	☐	☐	☐	788.1	Painful Urination
☐	☐	☐	780.8	Night Sweats	☐	☐	☐	578.0	Vomiting blood	☐	☐	☐	473.9	Sinusitis	☐	☐	☐	601.9	Prostate Trouble
☐	☐	☐	782	Numbness or Pain						☐	☐	☐	462	Sore Throats					
				in arms/legs/hands						☐	☐	☐	463	Tonsillitis					
☐	☐	☐	786.09	Wheezing															
			MUSCLES & JOINTS					**CARDIO-VASCULAR**					**SKIN OR ALLERGIES**					**FOR WOMEN ONLY**	
☐	☐	☐	724.5	Backache	☐	☐	☐	401.9	High Blood Pressure	☐	☐	☐	690	Boils	☐	☐	☐	625.3	Cramps or
☐	☐	☐	719.7	Foot Trouble	☐	☐	☐	458.9	Low Blood Pressure	☐	☐	☐	924.9	Bruising Easily					Backaches
☐	☐	☐	550.0	Hernia	☐	☐	☐	786.51	Pain over Heart	☐	☐	☐	701.1	Dryness	☐	☐	☐	626.2	Excessive Flow
☐	☐	☐	719.1	Pain Between	☐	☐	☐	785.9	Poor Circulation	☐	☐	☐	691.8	Eczema	☐	☐	☐	627.2	Hot Flashes
				Shoulders	☐	☐	☐	438	Previous Heart	☐	☐	☐	708.9	Hives or Allergy	☐	☐	☐	626.4	Irregular Cycle
☐	☐	☐	724.6	Painful Tail Bone					Trouble	☐	☐	☐	698.9	Itching	☐	☐	☐	634.9	Miscarriage
☐	☐	☐	723.9	Stiff Neck	☐	☐	☐	785.0	Rapid Heart	☐	☐	☐	782.0	Sensitive Skin	☐	☐	☐	625.3	Painful Periods
☐	☐	☐	781.9	Spinal Curvature	☐	☐	☐	427.89	Slow Heart	☐	☐	☐	368.9	Skin Eruptions	☐	☐	☐	623.5	Vaginal Discharge
☐	☐	☐	719.0	Swollen Joints	☐	☐	☐	436	Strokes						**YES**	**NO**			Pregnant at
☐	☐	☐	781.0	Tremors	☐	☐	☐	782.3	Swelling Ankles						☐	☐			this time?
☐	☐	☐	781.0	Twitching	☐	☐	☐	454	Varicose Veins										Last Menstrual Cycle

OPERATIONS AND PROCEDURES ☐ I have never had any operations/ surgeries

DATE		DATE		DATE	
	Vaccinations		Tubes in Ears		Sinus
	Tonsillectomy		Appendectomy		Hernia
	Gall Bladder		Female Organs		Thyroid
	Back Operation		Rectal Surgery		Stomach
	(list other surgery)		(list other surgery)		(list other surgery)

List the dates for any accidents or falls: ☐ *Auto* _____ ☐ *Sports* _____

☐ *Other* _____

List any broken bones, fractures or dislocations: _____

Ever been on crutches? _____ *Why?* _____

Have you ever had any spinal taps or spinal injections? ☐ *Yes* ☐ *No When?* _____

Have you ever been knocked unconscious? ☐ *Yes* ☐ *No When?* _____

Have you ever had a lapse of memory? ☐ *Yes* ☐ *No When?* _____

Have you ever had x-rays taken? ☐ *Yes* ☐ *No When?* _____

Where were the x-rays taken and for what reason? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ *and assign directly to Kevin Lee, DC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Kevin Lee, DC, may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.*

X

Patient/Guardian Signature *Date*

Gulf Coast Rehab & Wellness Center, 6250 Park Blvd., Pinellas Park, FL 33781

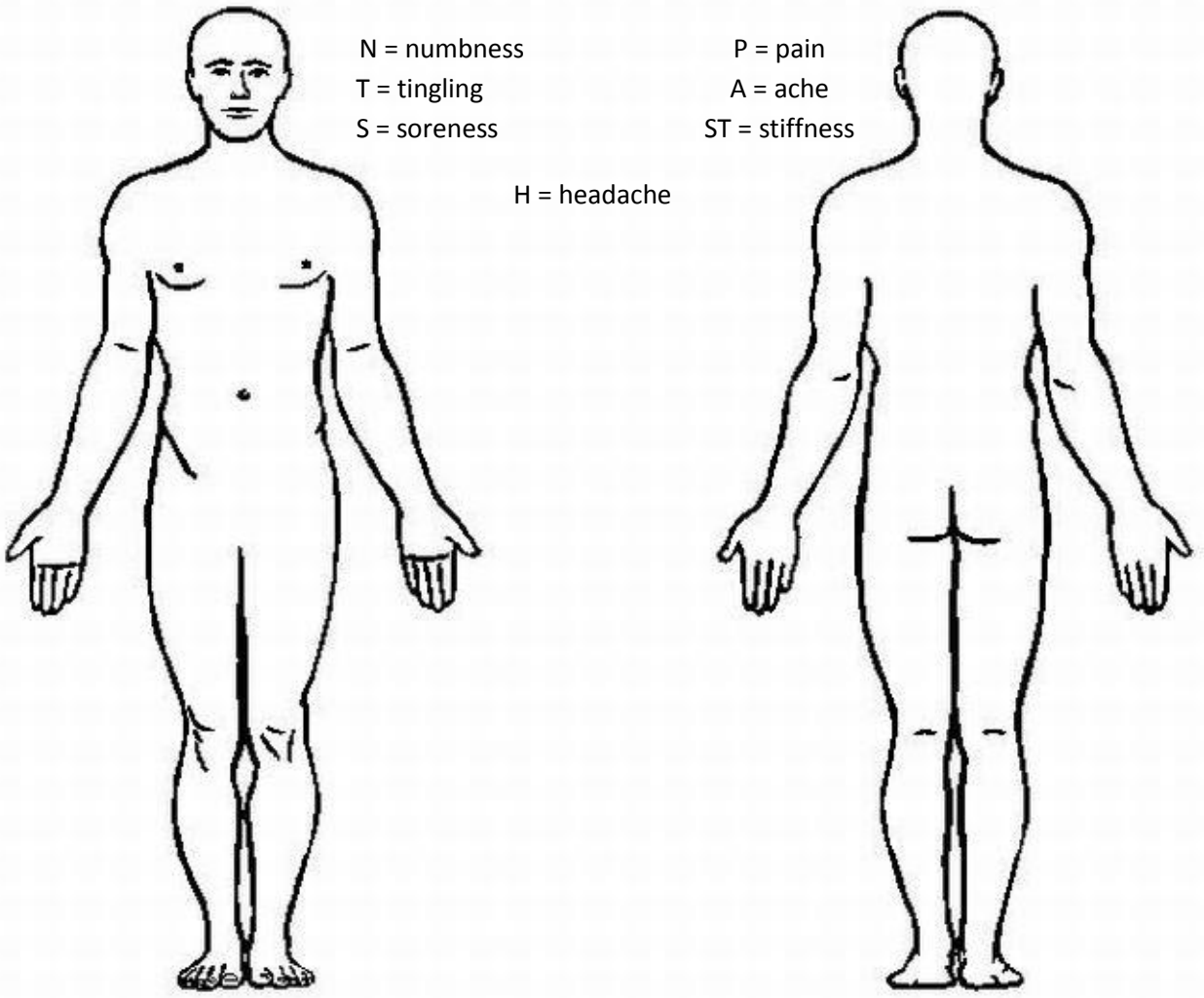
Date _____ Name _____

Please mark area and type of pain on the drawings using the codes listed.

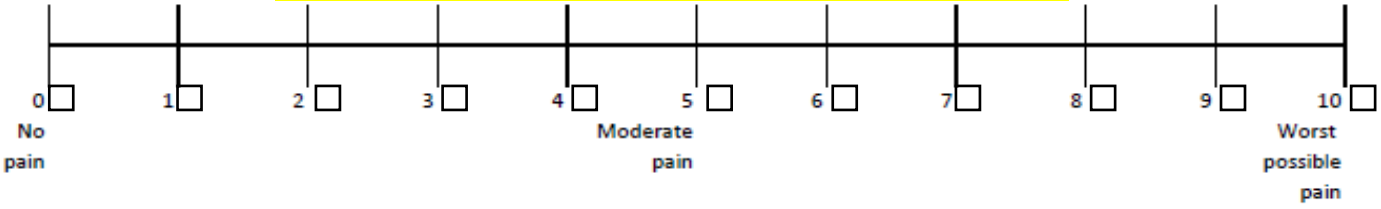
N = numbness
T = tingling
S = soreness

P = pain
A = ache
ST = stiffness

H = headache



Please circle a number describing how you feel overall today.



DOCTOR USE ONLY

_____

_____

_____

_____

_____

_____

_____

_____

_____

Additional Patient Information

Per federal standards please answer the following questions:

Name: _____ Date:_____

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ I do not wish to provide this information
- ☐ Other: _____

Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or non-Latino
- ☐ I do not wish to provide this information

Smoking Status

- ☐ Current every day smoker — Started smoking in (year): _____
- ☐ Current some day smoker — Ended smoking (year): _____
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known allergies
- ☐ Yes. What? _____

Are you currently taking any medications or supplements?

- ☐ Not currently taking any medications or supplements
- ☐ Yes:
  - _____ for _____
  - _____ for _____
  - _____ for _____
  - _____ for _____