Print Form

Clear Form Data

# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.


**The Chiropractic Place**
**Dr. Chad Luce, D.C.**
7051 Cypress Terrace, Suite 106
Fort Myers, FL 33907
(239) 887-3066


Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender ○ Male ○ Female

Nickname

Address of Permanent Residence

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

Ethnicity

City

State/Province

ZIP/Postal Code

Seasonal Address

Spouse's Name

City

State/Province

ZIP/Postal Code

Children's names and Ages

Home Phone

Cell Phone

Are you Medicare eligible? ☐ Yes ☐ No

If Yes, please present your Medicare card at the front desk, and please read our Special Notice to Medicare Patients. (Medicare replacement policies are not the same as Medicare)

Email Address

Emergency Contact

Emergency Contact's Phone

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City

State/Province

ZIP/Postal Code

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

## Request for Confidential Communication and Use of Email

Our office uses text messaging, as well as email to contact our patients regarding care, appointment reminders, holiday closures, or other announcements pertinent to our office.

Please read and complete the required areas to the right advising how you would prefer we disclose detailed and/or potentially sensitive information to you in the event we must contact you.

You may..

| | | |
|---|---|---|
| contact me via home and/or cell phone | ☐ Yes | ☐ No |
| leave a detailed message on my home answering | ☐ Yes | ☐ No |
| machine leave a detailed message on my cell phone | ☐ Yes | ☐ No |
| contact me via text message | ☐ Yes | ☐ No |
| mail correspondence to my home address | ☐ Yes | ☐ No |
| leave a detailed message with someone I trust | ☐ Yes | ☐ No |

If yes, who: Relationship: Phone #:

CONFIDENTIAL HEALTH INFORMATION

**1. The symptom(s) that have prompted me to seek care today include:** _____

_____

**2. And are the result of (darken circle):** ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

**3. Onset** (When did you first notice your current symptoms?)

_____

**4. Intensity** (How extreme are your current symptoms?)

0 ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ 10
Absent Uncomfortable Agonizing

**5. Duration and Timing** (When did it start and how often do you feel it?)

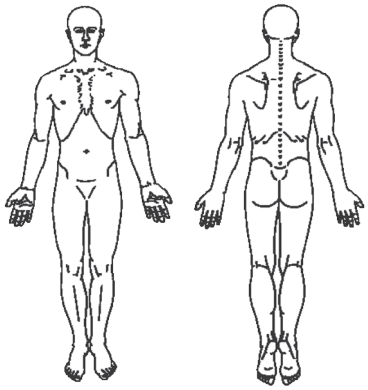
◯ Constant ◯ Comes and goes. How Often? _____

_____

**6. Quality of symptoms** (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

**7. Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



**8. Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

**9. Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

**10. Prior interventions** (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

**11. What else should the doctor know about your current condition?** _____

_____

**12. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household responsibilities:** _____

**Personal relationships:** _____

**13. Review of Systems**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Osteoporosis | ◯ | ◯ | Arthritis | ◯ | ◯ | Scoliosis | ◯ | ◯ | Neck pain | ◯ | ◯ | Back problems | ◯ | ◯ | Hip disorders |
| ◯ | ◯ | Knee injuries | ◯ | ◯ | Foot/ankle pain | ◯ | ◯ | Shoulder problems | ◯ | ◯ | Elbow/wrist pain | ◯ | ◯ | TMJ issues | ◯ | ◯ | Poor posture |

NONE ◯ Initials ____

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anxiety | ◯ | ◯ | Depression | ◯ | ◯ | Headache | ◯ | ◯ | Dizziness | ◯ | ◯ | Pins and needles | ◯ | ◯ | Numbness |

NONE ◯ Initials ____

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | High blood pressure | ◯ | ◯ | Low blood pressure | ◯ | ◯ | High cholesterol | ◯ | ◯ | Poor circulation | ◯ | ◯ | Angina | ◯ | ◯ | Excessive bruising |

NONE ◯ Initials ____

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Asthma | ◯ | ◯ | Apnea | ◯ | ◯ | Emphysema | ◯ | ◯ | Hay fever | ◯ | ◯ | Shortness of breath | ◯ | ◯ | Pneumonia |

NONE ◯ Initials ____

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anorexia/bulimia | ◯ | ◯ | Ulcer | ◯ | ◯ | Food sensitivities | ◯ | ◯ | Heartburn | ◯ | ◯ | Constipation | ◯ | ◯ | Diarrhea |

NONE ◯ Initials ____

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Blurred vision | ◯ | ◯ | Ringing in ears | ◯ | ◯ | Hearing loss | ◯ | ◯ | Chronic ear infection | ◯ | ◯ | Loss of smell | ◯ | ◯ | Loss of taste |

NONE ◯ Initials ____

**g. Skin**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Skin cancer | ◯ | ◯ | Psoriasis | ◯ | ◯ | Eczema | ◯ | ◯ | Acne | ◯ | ◯ | Hair loss | ◯ | ◯ | Rash |

NONE ◯ Initials ____

*Consultation Notes*

**Patient name** _____

**Patient Number** (office use only) _____

**Doctor's Initials** _____

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*(Continued from previous page)*

**h. Endocrine**

Had Have ◯ ◯ Thyroid issues | Had Have ◯ ◯ Immune disorders | Had Have ◯ ◯ Hypoglycemia | Had Have ◯ ◯ Frequent infection | Had Have ◯ ◯ Swollen glands | Had Have ◯ ◯ Low energy | NONE ◯ Initials ____

**i. Genitourinary**

Had Have ◯ ◯ Kidney stones | Had Have ◯ ◯ Infertility | Had Have ◯ ◯ Bedwetting | Had Have ◯ ◯ Prostate issues | Had Have ◯ ◯ Erectile dysfunction | Had Have ◯ ◯ PMS symptoms | NONE ◯ Initials ____

**j. Constitutional**

Had Have ◯ ◯ Fainting | Had Have ◯ ◯ Low libido | Had Have ◯ ◯ Poor appetite | Had Have ◯ ◯ Fatigue | Had Have ◯ ◯ Sudden weight gain/loss (circle one) | Had Have ◯ ◯ Weakness | NONE ◯ Initials ____

**Patient name** _____

**Patient Number** (office use only) _____

◯ All other systems negative

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

### 14. Illnesses

Clear Illness Selections

Check the illnesses you have **Had** in the past or **Have** now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ◯ | ◯ | AIDS | ◯ | ◯ | Tuberculosis |
| ◯ | ◯ | Alcoholism | ◯ | ◯ | Typhoid fever |
| ◯ | ◯ | Allergies | ◯ | ◯ | Ulcer |
| ◯ | ◯ | Arteriosclerosis | ◯ | ◯ | Other: _____ |
| ◯ | ◯ | Cancer | | | |
| ◯ | ◯ | Chicken pox | | | |
| ◯ | ◯ | Diabetes | | | |
| ◯ | ◯ | Epilepsy | | | |
| ◯ | ◯ | Glaucoma | | | |
| ◯ | ◯ | Goiter | | | |
| ◯ | ◯ | Gout | | | |
| ◯ | ◯ | Heart disease | | | |
| ◯ | ◯ | Hepatitis | | | |
| ◯ | ◯ | HIV Positive | | | |
| ◯ | ◯ | Malaria | | | |
| ◯ | ◯ | Measles | | | |
| ◯ | ◯ | Multiple Sclerosis | | | |
| ◯ | ◯ | Mumps | | | |
| ◯ | ◯ | Polio | | | |
| ◯ | ◯ | Rheumatic fever | | | |
| ◯ | ◯ | Scarlet fever | | | |
| ◯ | ◯ | Sexually transmitted disease | | | |
| ◯ | ◯ | Stroke | | | |

### 17. Allergies

Are you allergic to any medications?

Yes ◯ No ◯ If Yes please list: _____

### 15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery: _____
- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine _____
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: _____

### 16. Treatments

Clear Treament Selections

Check the ones you've received in the **Past** or are receiving **Currently**.

| Past | Currently | |
|---|---|---|
| ◯ | ◯ | Acupuncture |
| ◯ | ◯ | Antibiotics |
| ◯ | ◯ | Birth control pills |
| ◯ | ◯ | Blood transfusions |
| ◯ | ◯ | Chemotherapy |
| ◯ | ◯ | Chiropractic care |
| ◯ | ◯ | Dialysis |
| ◯ | ◯ | Herbs |
| ◯ | ◯ | Homeopathy |
| ◯ | ◯ | Hormone replacement |
| ◯ | ◯ | Inhaler |
| ◯ | ◯ | Massage therapy |
| ◯ | ◯ | Physical therapy |
| ◯ | ◯ | Medications |

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

### 18. Injuries

Have you ever...

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

*Consultation Notes*

### 19. Family History

Clear Family History Data

Some health issues are hereditary. Tell the doctor about the health of your immediate family members.

FAMILY

| Relative | Age (If living) | State of health Good | Poor | Illnesses | Age at death | Cause of death Natural | Illness |
|---|---|---|---|---|---|---|---|
| Mother | | ◯ | ◯ | | | ◯ | ◯ |
| Father | | ◯ | ◯ | | | ◯ | ◯ |
| Sister 1 | | ◯ | ◯ | | | ◯ | ◯ |
| Sister 2 | | ◯ | ◯ | | | ◯ | ◯ |
| Brother 1 | | ◯ | ◯ | | | ◯ | ◯ |
| Brother 2 | | ◯ | ◯ | | | ◯ | ◯ |
| _____ | | ◯ | ◯ | | | ◯ | ◯ |

**20. Are there any other hereditary health issues that you know about?** _____

### 21. Social History

Clear Social History Data

Tell the doctor about your health habits and stress levels.

SOCIAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ◯ Daily | ◯ Weekly | How much? _____ | Prayer or meditation? | ◯ Yes | ◯ No |
| Coffee use | ◯ Daily | ◯ Weekly | How much? _____ | Job pressure/stress? | ◯ Yes | ◯ No |
| Tobacco use | ◯ Daily | ◯ Weekly | How much? _____ | Financial peace? | ◯ Yes | ◯ No |
| Exercising | ◯ Daily | ◯ Weekly | How much? _____ | Vaccinated? | ◯ Yes | ◯ No |
| Pain relievers | ◯ Daily | ◯ Weekly | How much? _____ | Mercury fillings? | ◯ Yes | ◯ No |
| Soft drinks | ◯ Daily | ◯ Weekly | How much? _____ | Recreational drugs? | ◯ Yes | ◯ No |
| Water intake | ◯ Daily | ◯ Weekly | How much? _____ | | | |

Hobbies: _____

**Doctor's Initials** _____

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**22. Activities of Daily Living**
How does this condition currently interfere with your life and ability to function?

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Sitting | ◯ | ◯ | ◯ | ◯ |
| Rising out of chair | ◯ | ◯ | ◯ | ◯ |
| Standing | ◯ | ◯ | ◯ | ◯ |
| Walking | ◯ | ◯ | ◯ | ◯ |
| Lying down | ◯ | ◯ | ◯ | ◯ |
| Bending over | ◯ | ◯ | ◯ | ◯ |
| Climbing stairs | ◯ | ◯ | ◯ | ◯ |
| Using a computer | ◯ | ◯ | ◯ | ◯ |
| Getting in/out of car | ◯ | ◯ | ◯ | ◯ |
| Driving a car | ◯ | ◯ | ◯ | ◯ |
| Looking over shoulder | ◯ | ◯ | ◯ | ◯ |
| Caring for family | ◯ | ◯ | ◯ | ◯ |

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Grocery shopping | ◯ | ◯ | ◯ | ◯ |
| Household chores | ◯ | ◯ | ◯ | ◯ |
| Lifting objects | ◯ | ◯ | ◯ | ◯ |
| Reaching overhead | ◯ | ◯ | ◯ | ◯ |
| Showering or bathing | ◯ | ◯ | ◯ | ◯ |
| Dressing myself | ◯ | ◯ | ◯ | ◯ |
| Love life | ◯ | ◯ | ◯ | ◯ |
| Getting to sleep | ◯ | ◯ | ◯ | ◯ |
| Staying asleep | ◯ | ◯ | ◯ | ◯ |
| Concentrating | ◯ | ◯ | ◯ | ◯ |
| Exercising | ◯ | ◯ | ◯ | ◯ |
| Yard work | ◯ | ◯ | ◯ | ◯ |

**23. What is the major stressor in your life?** _____

**24. How much sleep do you average per night?** _____ **Hours**

**25. What is the type and approximate age of your mattress and pillow?** _____

**26. What is your preferred sleeping position?** _____

**27. Describe your typical eating habits**: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

**28. What would be the most significant thing that you could do to improve your health?** _____

**29. In addition to the main reason for your visit today, what additional health goals do you have?** _____

**Acknowledgements**
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

**If the patient is a minor child, print child's full name:** _____

Signature _____ Date (MM/DD/YYYY) _____

**Print Form**

**Patient name** _____

**Patient Number**
**(office use only)**

***Consultation Notes***

**Doctor's Initials** _____

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