Florida Chiropractic Institute
4641 Park Street North
St. Petersburg, FL 33709

PATIENT INFORMATION

Date:______________________

Patient Name:______________________________ Phone:______________________

Street Address:____

City:____________________________ State:________ Zip:__________

Gender: ( ) Female ( ) Male Date of Birth: ______________________
Race: Choose one or more that best describes your race:
( ) American Indian or Alaskan Native ( ) Asian ( ) Black or African American
( ) Hispanic or Latino ( ) Native Hawaiian or Other Pacific Islander ( ) White

Ethnicity: ( ) Non-Hispanic ( ) Hispanic

Preferred Language:____

Preferred Method of Contact: ( ) Phone ( ) Email ____________________
Do we have your permission to leave a voice mail at the phone number you have provided on this form? ( ) Yes ( ) No If no, Please provide us with an alternative way we may be able to either contact you or leave a message for you to return our call:

____

Surgeries: Please list any surgeries you have had within the past 10 years:
1. Type: ______________________________ Date: (approx):_______
2. Type: ______________________________ Date: (approx):_______
3. Type: ______________________________ Date: (approx):_______
Any Neck or Back Surgeries within the past 10 years? ( ) YES ( ) NO
If so, Please describe: ____

____

____

____

CURRENT MEDICATION LIST (List only medications you are currently taking):

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	

****PLEASE SEE OTHER SIDE FOR ADDITIONAL INFORMATION****

Any Medication Allergies? ( ) YES ( ) NO If yes, please describe the reaction:

___

___

Any Food/Environment Allergies?: If so, please describe the reaction:___

___

___

SMOKING STATUS: Have you ever smoked? ( ) YES ( ) NO
Do you smoke Currently? ( ) YES ( ) NO
If yes, how many packs per day? ___
Number of years you have/had smoked: ___

Family History: Mother: Still Living: ( ) Yes ( ) No
If Deceased, Cause of Death:___
Father: Still Living: ( ) Yes ( ) No
If Deceased, Cause of Death:___
Brothers: Still Living: ( ) Yes ( ) No
If Deceased, Cause of Death:___
Sisters: Still Living: ( ) Yes ( ) No
If Deceased, Cause of Death:___

TO BE COMPLETED BY STAFF

VITALS: Blood Pressure: LT: ___ RT ___

Height: ___ Weight: ___

REASON FOR VISIT TODAY:___

___

___

CONFIDENTIAL QUESTIONNAIRE

Appt. Date: ______________________ Appt. Time: ____________ Dr. K B F

Name: ______________________________ Home Phone: ______________

Address: ______________________________ Cell Phone: ______________

City: __________________________ State: ____________ Zip: __________

Age: _____ Birthdate: ______________ Referred by: ______________________

Employer: ____________________ Occupation: ______________________

Employer's Address: ____

Work Phone #: ____________________ Soc. Sec. No. ____________________

Marital: S / M / D / W Spouse's Name: ______________ Children: ______________

Emergency Contact: ________________________ Relationship: ______________

Phone: ____________

PCP Name: ________________________ Phone: ____________

May we have permission to contact your PCP if needed? ____Yes ____ No Please Initial______

★★★

Major Complaint: ____

How long have you had this problem? __________

Describe any serious accidents or illnesses you have had: ______________________

____

Are you pregnant? Yes ☐ No ☐

List any operations you have had: ______________________________________

Have you been treated for any health conditions in the past year? If yes, please describe: ______________

____

Family history: Please indicate any known health disorders: ______________________

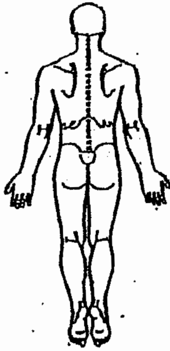
Mother: Living / Deceased; Age: _____; Comments: ______________________________

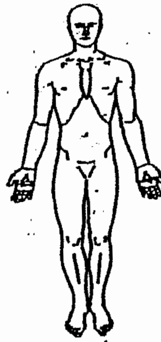
Father: Living / Deceased; Age: _____; Comments: ______________________________

Sisters / Brothers; Comments: ______________________________________

Florida Chiropractic Institute has an ongoing credit policy for our clients. Our terms are net 30 days. Late charges of 1% per month (12% APR) will be assessed on past-due accounts and collection charges and/or attorney fees may be added.

Please use the diagram below to indicate your areas of pain or unusual feeling:





Numbness	Pins & Needles	Burning
- - - - -	oooooo	xxxxxxx
- - - - -	oooooo	xxxxxxx
- - - - -	oooooo	xxxxxxx

Aching	Stabbing
*****	/////
*****	/////
*****	/////

	Pain Rating			
Neck, Shoulder, Arm	0	Mild	Mod	Severe
Midback	0	Mild	Mod	Severe
Lowback, Leg	0	Mild	Mod	Severe

Major Complaint:__________

______________________________________ __________

How long have you suffered with this problem?:This latest episode: ______________________

Previous episodes: ____

Names of other physicians consulted for this condition: ______________________

Describe things that make the pain worse: ______________________________

Describe things that make the pain better: ______________________________

Do you now have or have you ever suffered from any of these?

	Past	Present		Past	Present		Past	Present
Dizziness:	____	____	Diabetes:	____	____	Heart:	____	____
Headaches:	____	____	Cancer:	____	____	Kidney:	____	____
Neck pain:	____	____	Anemia:	____	____	Urinary:	____	____
Stiff neck:	____	____	Prostate:	____	____	Digestive disorders:	____	____
Back pain	____	____	Neuritis:	____	____	Tuberculosis:	____	____
Hip or leg pain	____	____	Nervousness:	____	____	High blood pressure:	____	____
Sleeplessness:	____	____	Female problems:	____	____	Numbness of the arms:	____	____
Asthma:	____	____	Palpitations:	____	____	Numbness of the legs:	____	____
Arthritis:		____	____	Rheumatic Fever:	____	____		

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I understand and agree that health and accident insurance are an arrangement between my insurance company and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable.

I hereby authorize the release of any medical or other information necessary to process these claims. As well, I authorize payment of medical benefits to this office, physician or supplier for services or supplies rendered.

Patient's Signature:________________________________ Date:______________

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Authorization to treat minor child: ________________________________

Relationship to child:____________________ Parent/Guardian's Daytime Phone______________

Florida Chiropractic Institute - 4641 Park Street North - St. Petersburg, FL 33709 (727) 544-7878