14270 Spring Hill Drive
Spring Hill Fl. 34609
T:352-684-1484 – F: 352-684-1420

Patient Information:
Date:_____

Please fill out Everything:

First Name: _____M.I._____ Last Name:_____
Sex:____ D.O.B:_____ Social Security Number:_____
Address:_____
___
City: _____ State: _____ Zip:_____
Home Phone: ( )_____ Cell Phone: ( )_____
E-Mail Address
_____
Emergency Contact Name & Relationship:_____Number:_____

Insurance Information:

Insurance Carrier:_____
Address:_____
___
City:_____ Sate: _____
Phone:_____
Policy Number:_____
Claim Number:_____

Employer Information:

Name of Employer:_____
Occupation:_____Work Duties:_____
Address:_____
_____

City:_____ State: _____Zip:_____ Phone: ( )_____

Personal History:

Single: _____ Married: _____ Divorced: _____ Widow: _____
Number of children:_____ Grand children :(if any)_____
Do you Smoke:_____ If so how much:_____ How long:_____
Do you Drink:_____ If so how much:_____
Are you on any Medications:_____
If so, Please list them: _____
_____
Are you allergic to any Medications:_____
If so, please list: _____
Do you Take Vitamins: _____

Past Medical History:

Please list any Auto Injuries that you may have had in the pass 5 years:_____
_____
Did you ever see a Doctor for this Injury? _____
If so when: _____
Please list any other Injuries that you may have had in the pass 5 years: _____
_____
Did you ever see a Doctor for this Injury? _____
If so when: _____
Please list Any Surgeries that you have had, along with the Dates: _____
_____
_____

Family History:

Father Still Alive? _____ Age: _____
If not, what Illnesses did he pass from?:
_____
Mother Still Alive? _____ Age: _____
If not, what Illnesses did she pass from?:
_____

Any Brothers or Sisters? If so how many and what age:
_____
_____
____

The Reason for this visit is a Result of (Please circle one)

Work Sports Auto Trauma Chronic Maintenance
Other:_____

Date of Accident or Trauma :_____

If work related, Did you miss any time from work? :
_____
If so, how much: _____ Dates of time missed:
_____
Are you in any pain?:_____
Please Describe your pain and give location:
_____
When did this Condition
begin:_____
Is the Condition : (Please check one) Getting worst:_____ Staying the same:_____
Getting better:_____ Comes and goes:_____
Other:_____

Is this Condition Interfering with (Please check one) : Work:_____
Sleep:_____
Driving:_____ Walking:_____ Daily Activities:_____
Other:_____
If so, Please
explain:_____
Have you ever had the same or similar condition in the
past?:_____
If so, Please
explain:_____
Have you ever been in an Auto Accident before?: _____
Date:_____
Have you had any other Injuries or Accidents?
_____
Have you ever been seen by any Other Physicians or Health Practitioners relating to this Incident or Injury? : _____
If yes, Please explain:
_____

Please read and sign below

Your appointment may include any of the following: examination, evaluation, diagnosis, chiropractic adjustment and physio-therapy.

Time for your care has been **reserved especially for you** in order to best car for your health and well being. Appropriate staffing has also been reserved for you. Therefore we request that you notify us as soon as possible if you must re-schedule/cancel your appointment for any reason. We reserve the right to charge $25.00 for missed appointment without prior cancellation notification.

Patient Signature_____**Date**_____