

PATIENT INFORMATION

First Name _____ Last Name _____

Gender: M F Date of Birth ___ / ___ / ___ Age _____ SS# _____ / _____ / _____

Home Address _____

City _____ State _____ Zip _____

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

Employer _____ Occupation _____

Referred By _____ Email _____

Do you have an attorney? Yes No

Attorney name: _____ Attorney telephone: _____

SPOUSE or GUARDIAN

First Name _____ Last Name _____

Employer _____ Occupation _____

Work Phone: _____ Cell Phone: _____

Date of Birth ___ / ___ / ___ Age _____ SS# _____ / _____ / _____

MY PRIVACY - HIPAA

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

Print Name: _____ Sign Name: _____

CONSENT TO TREAT MINOR

I hereby authorize Dr. Pari Limbachia, D.C. and whomever they may designate to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child)

Name of Child: _____

Information concerning sexual activity, alcohol use and/or substance abuse will not be disclosed to you the parent/guardian without consent of your child. Any information concerning suicide ideation or homicide ideation will be disclosed to you immediately. This information is regulated by Florida State Law and HIPAA.

Guardian Name: _____ Guardian Signature: _____

DISCLOSURE OF MEDICAL INFORMATION

Please provide the name, phone number and relationship of the person(s) to whom you want to disclose your personal health information.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Print Name: _____ Sign Name: _____

Witness: _____ **Sign Name:** _____

DATE OF ACCIDENT: _____ Hour: _____ AM PM

Please describe the accident in detail:

Location of Accident: Street: _____ City: _____

Type of vehicle you were in: _____ Speed: _____

Type of other vehicle involved: _____ Speed: _____

Did anyone witness the accident? Yes No Did you report the injury to your employer? Yes No

Were you: Driver Passenger Front seat Back seat Pedestrian

Were you struck from: Behind Front Left Side Right Side

Direction heading: North South East West Vehicle stopped? Yes No

Did your vehicle strike another vehicle? Yes No Did their vehicle strike your vehicle? Yes No

Did the driver of your vehicle get a ticket? Yes No Did the driver of the other vehicle? Yes No

Did you strike any objects in the car? Yes No

Steering Column Rearview Mirror Dashboard Back seat

Door Frame Headrest Can't Remember Other

What portion of your body did you strike?

Head Chest Face Knees Arms Other

Were you rendered unconscious, cut or bleeding? Yes No

If cut, please explain where: _____

Wearing seat belts? Yes No What kind? Lap Shoulder Lap/Shoulder

Did airbags deploy? Yes No

Were police notified? Yes No After the accident, did you: Go home Go to hospital

Were you admitted to the hospital? Yes No

If yes, please give the name of the hospital: _____

What date(s) were in the hospital? _____ Estimate of total charges: _____

What was done in the hospital?

Exam Stitches X-Rays MRI CT Scan Therapy Other

Have you lost any days from work due to this accident? Yes No Estimate of wages lost: _____

Date(s) missed: _____ Type of employment: _____

GENERAL SYMPTOMS

Check symptoms you have noticed since the accident:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Head seems to heavy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Chief complaint: _____

Complaint began when: _____ Duration of complaint: _____

Is condition getting worse: _____ Condition interferes with: _____

How frequent is it and how long does it last: _____

Circle the Quality of the pain: dull aching sharp shooting burning throbbing deep nagging other: _____

Does any pain radiate or travel to any areas of your body: _____

Do you have any numbness or tingling in your body: _____

Grade pain Intensity/Severity: (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain)

Does anything aggravate the complaint: _____

Does anything make the complaint better: _____

Previous doctors, treatments, medications, or surgery you've sought for your complaint: _____

PAST HEALTH HISTORY:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

C. Allergies: _____

D. Medications:

Medication you are now taking

Reason for taking

_____	_____
_____	_____
_____	_____

E. Surgeries:

Date

Type of Surgery

_____	_____
_____	_____
_____	_____

F. Females:

Pregnancies/Date of Delivery

Outcome

_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period: _____

FAMILY HEALTH HISTORY:

1. Associated health problems of relatives: _____

2. Deaths in immediate family:

Cause of parents or siblings death

Age at death

_____	_____
_____	_____
_____	_____

SOCIAL AND OCCUPATIONAL HISTORY:

A. Level of Education: high school some college college graduate post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Level of activity: sedentary moderate active very active

F. Lifestyle (hobbies, alcohol, tobacco and drug use, diet): _____

Please check all conditions you currently have or have had

General Questions

- Weight loss
- Weight gain
- Change in sleep patterns
- Change in activity capacity

Neurologic and Psychiatric

- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

Ears, Eyes, Nose & Throat

- Hay fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear Infections
- Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infections
- Swollen glands

Cardiovascular

- Angina
- Leg cramps
- Ankle swelling
- Awakening short of breath
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins

Respiratory

- Pleurisy
- Wheezing
- Asthma
- Breathlessness when lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Tuberculosis
- Pneumonia
- Shortness of breath
- Frequent infections (bronchitis)

Skin

- Abscess
- Acne
- Boils
- Hives
- Lumps
- Jaundice
- Psoriasis
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles- irregular
- Moles - change/new
- Dandruff
- Oily skin
- Rashes
- Dry skin

Kidneys & Urinary Tract

- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/incontinence
- Urinating frequently (day)
- Urinating frequently (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

Endocrine

- Diabetes
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Increased loss of hair
- Rheumatism
- Thyroid disease
- Sickle cell

Male & Female

- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases

Males Only

- Hernia
- Bloody ejaculation
- Inability to complete intercourse
- Lump on testicle
- Penile discharge
- Sterility
- Sores on penis or warts
- Prostate disease
- Testicular pain
- Testicular swelling

Musculoskeletal

- Anemia
- Back pain
- Gout
- Neck pain
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy Bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches
- Arthritis
- Bursitis
- Joint aches
- Tendonitis

Gastrointestinal

- Diarrhea
- Reflux
- Ulcers
- Hepatitis
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal Hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movement
- Gallstones
- Vomiting
- Heartburn
- Indigestion

Females Only

- D + C
- Hernia
- Endometriosis
- Abn. bleeding between cycles
- Abnormal pap smear
- Bleeding after intercourse
- Complications with pregnancy
- Heavy bleeding during cycles
- Ovarian cysts
- Pelvic Inflammatory Disease
- Postmenopausal symptoms
- Hot flashes
- Fibroids
- PMS

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Shant Wellness to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____

Date: _____

Doctors Signature: _____

Date: _____