CONFIDENTIAL HEALTH INFORMATION (**Auto**)

Name:_____ Date:_____ Pat. # _____

Address:_____City:_____ State:_____ Zip:_____

Email _____ Cell Phone (&carrier)_____

Home Phone:_____ Date of Birth:_____ Social Security # _____

Occupation: _____ Employer's Name:_____ Work Phone:_____

Marital Status (circle): Married Single Divorced Widowed Separated Spouse's Name_____ Spouse Ph.# _____

Your Age _____ Gender (circle): Male Female # Children _____ Spouse's Occupation _____

How did you hear about us — or whom may we thank for referring you?_____

Have you seen a chiropractor before — if so, When? _____ If so, Who?_____

Primary Care Provider _____ Preferred Contact Method: ○ Home ○ Cell ○ Work ○ Email

Primary Complaint/Present Health Condition

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

_____

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other_____

_____

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other

_____

Onset (When did you first notice your current symptoms?) _____

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

○ Prescription Meds	○ Acupuncture
○ Over-the-counter	○ Chiropractic
○ Homeopathic	○ Massage
○ Physical therapy	○ Ice
○ Surgery	○ Heat

○ Other _____

_____

Secondary Complaint
The primary symptom that prompted me to seek care today is: _____

_____

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other _____

_____

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other

_____

Onset (When did you first notice your current symptoms?) _____

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

○ Prescription Meds	○ Acupuncture
○ Over-the-counter	○ Chiropractic
○ Homeopathic	○ Massage
○ Physical therapy	○ Ice
○ Surgery	○ Heat

○ Other_____

_____

Additional Complaint
The primary symptom that prompted me to seek care today is: _____

_____

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other _____

_____

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other

_____

Onset (When did you first notice your current symptoms?) _____

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

○ Prescription Meds	○ Acupuncture
○ Over-the-counter	○ Chiropractic
○ Homeopathic	○ Massage
○ Physical therapy	○ Ice
○ Surgery	○ Heat

○ Other _____

_____

- What makes your current symptom(s) worse? _____

  _____
- Have you had similar health problems or injuries before? No ____ Yes (explain)_____

  _____
- How does your current condition interfere with your:
  Work or career: _____
  Recreational activities: _____
  Household responsibilities: _____
  Personal relationships: _____

CONFIDENTIAL HEALTH INFORMATION

Previous Health History

When were you last seen by your primary care/family physician? _____
May we send them updates on your treatment/condition: ☐ **Yes** ☐ **No**

Are you allergic to any medications? ☐ **No** ☐ **Yes** _____

During the last year, has a doctor treated you for any health problem? ☐ **Yes** ☐ **No**
If yes, please explain: _____

If you answered yes to seeing a Chiropractor before — what did you see him or her for — and what was your experience? _____
_____

Please check the prescription drugs you are currently taking: □Anti-depressants □Anti-Inflammatory
□Birth Control Pills □Blood Pressure Medication □Diet Pills □Blood Sugar Medication
□Muscle Relaxers □Insulin □Pain Pills □Sleeping Pills
Other (please list):_____
_____

Please check the over the counter drugs you are using and how much your take:
□Aspirin:_____ □Tylenol:_____ □Motrin:_____ □Aleve:_____
□Advil:_____ □Other:_____

List the approximate dates of any accidents, operations, illnesses, or serious injuries (including broken bones) you have had: _____
_____
_____

List any vitamins or nutritional supplements you have taken recently or currently taking: _____
_____
_____

Check any of the following you are interested in learning more about or would like information on:
□Massage Therapy □Acupuncture □Nutrition Testing □Live Blood Cell Analysis □Spinal Decompression
□Physician Supervised Weight Loss □Wellness Coaching □Health Workshops and Seminars

Financial Responsibility

Who is responsible for your bill? □Insurance □My Employer □Spouse □I am □Other
Type of Insurance: □Automobile □Health □Worker's Comp
Insurance Company's Name, Address and Phone #: _____
_____

Your fees are due and payable at the time services are received, unless other arrangements have been made in advance. X-rays remain property of this clinic, but may be signed out.

I, the undersigned, hereby give permission for treatment.

Patient's (Guardian) Signature:_____ Date: _____

Family Health History

Some health issues may be hereditary, please fill out the following for Dr. Roffler

Relative	Age (if living)	Age at death (if deceased)	Illnesses/Health Problem
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Race

☐ American Indian ☐ Alaskan Native
☐ Black or African American ☐ White
☐ Native Hawaiian ☐ Other Pacific Islander
☐ Asian ☐ Other ☐ Decline to Answer

Ethnicity

☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Decline to specify

Treatments: Check **Past** or are receiving **Currently**

Past	Current		Past	Current	
☐	☐	Acupuncture	☐	☐	Homeopathy
☐	☐	Antibiotics	☐	☐	Hormone Replacement
☐	☐	Birth Control pills	☐	☐	Inhaler
☐	☐	Blood Transfusions	☐	☐	Massage Therapy
☐	☐	Chemotherapy	☐	☐	Physical Therapy
☐	☐	Chiropractic care	☐	☐	Decompression Therapy
☐	☐	Dialysis	☐	☐	Nutritional Therapy
☐	☐	Herbs	☐	☐	Medications

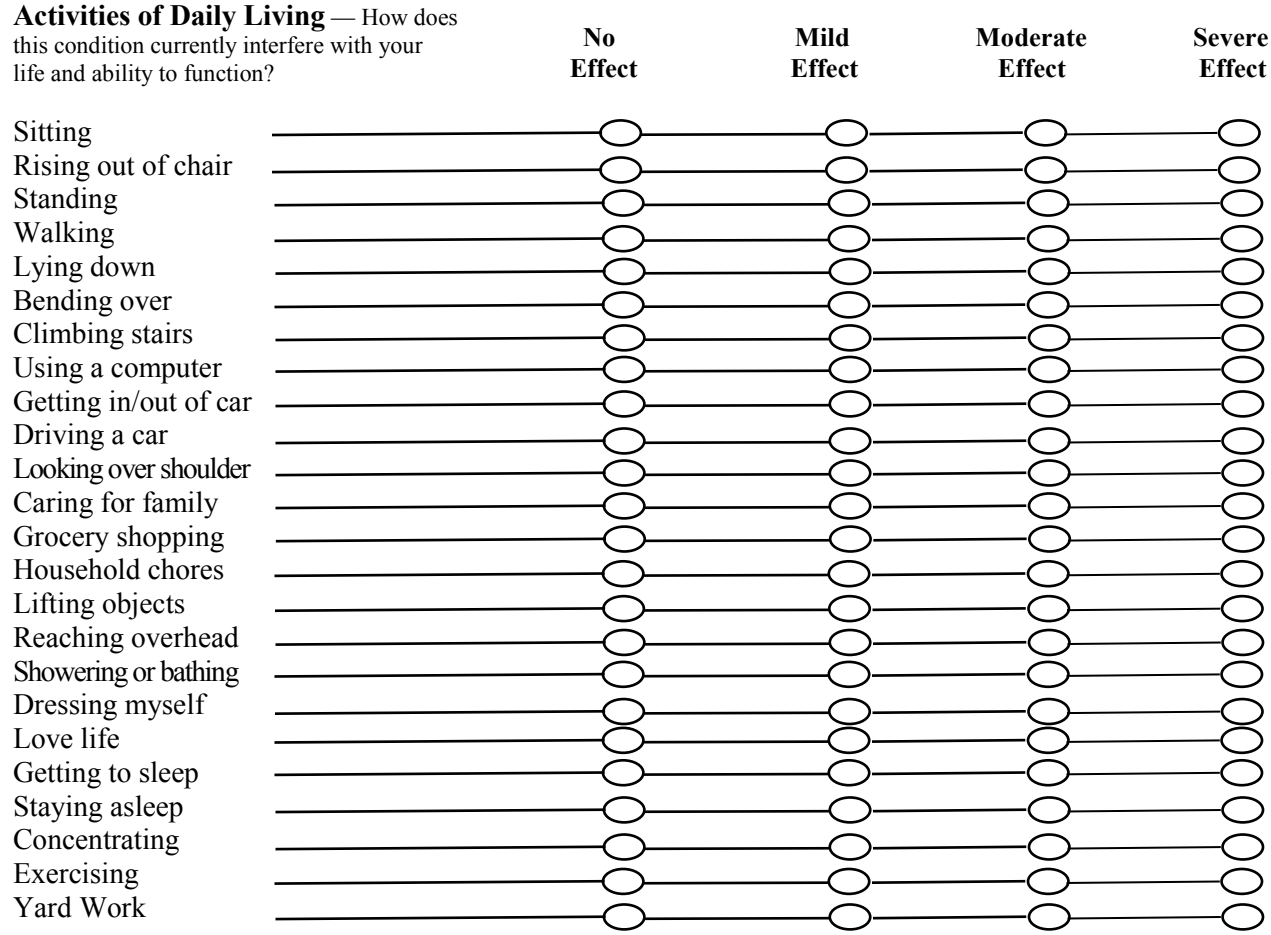
Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily:_____
Do you drink? □ Yes □ No If yes, how many drinks/week:_____
Do you exercise regularly? Yes / No If yes, describe what type and how often:_____
_____
Do you consider yourself to have a good social support system (friends/family)? Yes No
Describe a typical daily diet (only include meals/snacks you regularly eat):
Breakfast:_____ Snack (time eaten): _____
Lunch: _____ Snack (time eaten): _____
Dinner: _____ Snack (time eaten): _____

Review of Systems (Check any symptoms you've had in the past year)

□ Muscle Pain	□ Fever	□ Chills	□ Fatigue	□ Eye pain	□ Blurred vision
□ Double vision	□ Headaches	□ Joint swelling	□ Nosebleed	□ Ringing in ears	□ Chest pain
□ Skin changes	□ Fainting	□ Wheezing	□ Chest tightness	□ Anxiety	□ Heartburn
□ Nausea	□ Vomiting	□ Constipation	□ Diarrhea	□ Bloody stool	□ Joint stiffness
□ Difficult/ painful urination	□ Unexpected weight loss or gain	□ Difficulty swallowing	□ Heart Palpitations	□ Poor wound healing	□ Shortness of breath
□ Depression	□ Tremors	□ Seizures	□ Easy bleeding/ bruising	□ Excessive thirst or urination	□ Allergic Reactions

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



What is the major stressor in your life? _____ How much sleep do you average per night?_____ Hours

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

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

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.

Initial Ea.

_____ I instruct Dr. Roffler to deliver the care that, in his professional judgment, can best help me in the restoration of my health. Chiropractic is designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ 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.

_____ 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)_____

_____ 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.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ 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(s).

_____ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care).

_____ _____ _____

Patient (or Guardian) Signature | Date (MM/DD/YYYY) | Doctor Initial

AUTOMOBILE ACCIDENT HISTORY

Winter Park Spine & Injury

NAME _____ **TODAY'S DATE** _____

FIRST MI LAST

PRIOR AUTO ACCIDENTS? YES ___ NO ___ Dates of _____

EXTENT OF INJURIES?_____

TREATMENT: _____

IMPAIRMENT/DISABILITY: _____

ANY PREVIOUS RESTRICTIONS / LIMITATIONS? _____

OTHER (PREVIOUS) INJURIES, HEAD, NECK, BACK, EXTREMITIES, DUE TO:

FALLS: _____

SPORTS: _____

OTHER: _____

IN DETAIL DESCRIBE HOW CURRENT ACCIDENT HAPPENED: _____

_____

_____

_____

LIST ALL SYMPTOMS YOU HAVE NOTICED SINCE THE RECENT ACCIDENT: _____

_____

_____

_____

DATE PRESENT ACCIDENT OCCURRED _____

LOST DAYS AT WORK? YES _____ NO _____ HOW MANY/DATES: _____

MY INSURANCE COMPANY: _____

HAVE YOU BEEN CONTACTED BY AN ADJUSTER FOR THIS CLAIM?: YES _____ NO _____

DO YOU HAVE AN ATTORNEY FOR THIS CLAIM?: YES _____ NO _____

NAME (Attorney): _____ PHONE: _____

Patient Signature _____