CONFIDENTIAL HEALTH INFORMATION

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_____
_____

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_____

Intensity of pain (circle number**)**
1—2—3—4—5—6—7—8—9—10

Duration (How often do you feel it)?
○ Consistent ○ Frequent ○ Occasional

Quality of Symptoms: (Circle ALL that apply)
Numbness Aching Burning Tingling Radiates
Shooting Stiffness Dull Sharp Stabbing
Other _____

Aggravates: _____
Helps: _____

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_____
_____

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 _____

Intensity of pain (circle number**)**
1—2—3—4—5—6—7—8—9—10

Duration (How often do you feel it)?
○ Consistent ○ Frequent ○ Occasional

Quality of Symptoms: (Circle ALL that apply)
Numbness Aching Burning Tingling Radiates
Shooting Stiffness Dull Sharp Stabbing
Other _____

Aggravates: _____
Helps: _____

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_____
_____

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 _____

Intensity of pain (circle number**)**
1—2—3—4—5—6—7—8—9—10

Duration (How often do you feel it)?
○ Consistent ○ Frequent ○ Occasional

Quality of Symptoms: (Circle ALL that apply)
Numbness Aching Burning Tingling Radiates
Shooting Stiffness Dull Sharp Stabbing
Other _____

Aggravates: _____
Helps: _____

Winter Park Spine & Injury

Supplemental Health History

Have you had similar health problems or injuries before: Yes ☐ No ☐ Explain:

_____

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

_____

_____

Have you ever seen 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: _____

_____

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: _____

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 examination & treatment.

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

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				
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard Work				
Career/Job				

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

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

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