Pompano Beach Chiropractic Clinic
4 NE 4th Ave., Pompano Beach, FL 33060
PH: 954-943-1044, www.pompanochiro.com

Date: _____

File No._____

Name_____ Day/Night Phone _____
Res. Address_____ City_____ State_____ Zip_____
Date of Birth _____Age_____ Sex: M____ F____ Height _____ Weight_____
Employer_____ Occupation_____ Work Ph _____
Address_____ City _____State _____ Zip _____

Marital Status M S D W Number of Children: Boys [ ] Girls [ ]
Name of Spouse _____Spouse's Occupation_____
Spouse's employer (name, address, city, ph)_____
_____
Emergency Contact _____Phone Number_____
Referred by _____ Person Financially responsible_____
* (If patient is a child, fill out above work information etc., for parent)

Consent To Treat

I _____ hereby consent, authorize and request Pompano Beach Chiropractic Clinic to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with his/her expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications, which may result from such treatment.

Patient's Signature_____
Print Name_____ Date _____
Witness _____Print Name _____ Date _____

Family History

Parents living: Father (age)_____Mother _____ Brothers_____ Sisters _____
Is there any History of:
Diabetes_____ Asthma_____ Cancer_____ Mental Disease _____
Heart Disease_____ Lung Disease_____ Arthritis_____ Allergies _____
Any Other (specify) _____

Personal History

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ , Unusual childhood diseases y/n , if yes ,explain_____
Do you smoke? y/n, How many? _____ Do you drink coffee? y/n , How much? _____ Do you drink alcohol? y/n, How much? _____ Do you take any drugs? y/n, List Names _____
_____

Do you take any vitamins? y/n, List Names_____
_____
Do you exercise? Regularly____ Infrequently_____ Seldom_____ Not at all_____ Are you pregnant now? y/n if yes, how many weeks_____ FIRST DAY OF YOUR LAST MENSTRUAL PERIOD _____
Do you have a pacemaker? y/n, Hobbies if any? _____

Past History

List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates.
_____
Have you had any previous back troubles? y/n, If yes, describe and give dates.
_____
_____
List any past significant illness_____
List all operations (give dates)_____
Are you taking any medications now? y/n, if yes, please list_____
_____
List any known allergies_____
List all abnormalities_____
Have you seen a chiropractor before? y/n, Last Adjustment _____
Name and Address of your D.C. _____
Last Physical Exam_____ Findings _____
Have you taken X-rays in the last two years? y/n, What part of your body? _____
If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, ect.
_____
_____
Chief complaint (please describe fully) _____
_____
Duration of present condition?_ _____What do you believe caused this condition ?_____
_____ Is your condition due to an accident or illness? _____
If due to an auto accident or injury at work, please specify_____
_____
Please put an X by any symptoms that you suffer from

_____ Headaches	_____ Excessive Gas
_____ Hot Flashes	_____ Insomnia
_____ Blurred Vision	_____ PMS
_____ Dizziness	_____ Poor Memory
_____ Morning Fatigue	_____ Sexual Impotency
_____ General Fatigue	_____ Excessive Perspiration
_____ Labored Breathing	_____ Palpitation of the chest
_____ Shortness of Breath	_____ Dry Skin
_____ Indigestion	_____ Poor Appetite
_____ Heartburn	_____ Excessive Appetite
_____ Lump in the throat	_____ Night Sweats
_____ Throat Constriction	_____ Nerves
_____ Numbness	_____ Depression
_____ Fainting Spell	_____ Learning Disabilities
_____ Light Headedness	_____ Asthma
_____ Swelling of the joints	_____ Chemical Sensitivities
_____ Loose stools	_____ Constipation

Please list any additional symptoms that you suffer from.

When were you last seen by a physician? _____For what purpose? _____
Your doctor's name? _____ Specialty_____
Doctor's address_____
City_____ State_____ Zip_____ Phone_____
Diagnosis _____

List all foods and beverages taken more that three times a week_____

Physical Examination

To be filled in by the Doctor

Temp: _____ Pulse: _____ Resp: _____
Blood Pressure: Sitting _____Lying _____
General Appearance: _____
Labwork_____
Diagnosis_____
Treatment Plan _____
Notes _____