
464073 State Rd 200, Ste. #4
Yulee, FL 32097
904.780.5050

**WELCOME**

The doctors and staff of theCoastal Chiropractic Clinic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition(s) will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

**PATIENT IDENTIFICATION & INFORMATION**

Today's Date: _____

Name: _____ Age: _____ DOB: _____

Preferred name for office use _____ Male ☐ Female ☐ Marital Status: ☐ M. ☐ W. ☐ D. ☐ S.

Street: _____ Apt#: _____SS#: _____

City: _____ State: _____ Postal Code: _____

Telephone: (Home): _____ Number of Children: _____

(Cell): _____ Email: _____

(Work): _____ Occupation: _____

Ok to call Work? Yes ☐ No ☐

Would you like to receive appointment reminders? ☐ Yes (Circle one): ☐ Email / ☐ Text ☐ No

Cell Phone Provider: AT&T/Verizon/Sprint/US Cellular/_____

When would you like a reminder sent? (Circle one): 30 min / 45 min / 1 hr / 2 hrs / 4 hrs / 1 day / 2 days prior

☐ ☐ ☐ ☐ ☐ ☐ ☐

Support Contact: Name: _____ Relationship: _____

Telephone: _____

## INFORMATION/APPLICATION FOR CARE

The following information is needed to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT**.

Please circle one payment type: Cash Check Master Card/Visa

Do you have Medicare/Medicaid? Yes_____ No_____

Your Employer: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

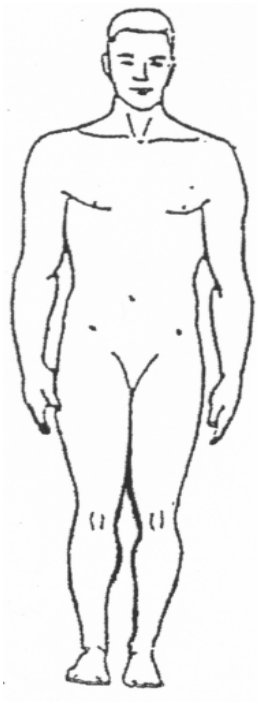
Name of Spouse/Parent: _____ DOB: _____ Occupation: _____

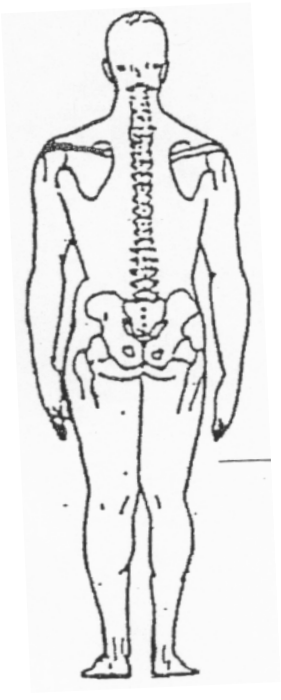
Spouse/Parent Employer: _____ Wk Phone: _____

Years on Job: _____

Employer Address: _____ City: _____ State: _____

Zip: _____





### COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off and on, when standing when sitting, etc.

### MAJOR COMPLAINTS

(Please list any condition you are being treated for or experiencing)

_____

_____

_____

_____

_____

_____

Referred to our office by: _____

Is your condition due to an Accident? Yes ☐ No ☐ Date of Accident: _____
Type of Accident? Auto: _____ Work/On Job: _____ At Home: _____ Other: _____
Have you ever been in an Auto Accident? Past Year: ☐ Past 5 Years: ☐ Over 5 Years: ☐ Never: ☐

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

**Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.**

# CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Date: _____

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please check the appropriate box for any of the following symptoms that you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O**–Often **F** – Frequent **C** – Constant

| GENERAL | O | F | C |
|---|---|---|---|
| Allergy | | | |
| Chills | | | |
| Convulsions | | | |
| Dizziness | | | |
| Fainting | | | |
| Fatigue | | | |
| Fever | | | |
| Headache | | | |
| Loss of sleep | | | |
| Loss of weight | | | |
| Nervousness/Depression | | | |
| Neuralgia | | | |
| Numbness | | | |
| Sweats | | | |
| Tremors | | | |

| MUSCLE & JOINT | O | F | C |
|---|---|---|---|
| Bursitis | | | |
| Foot trouble | | | |
| Hernia | | | |
| Low back pain | | | |
| Lumbago | | | |
| Neck pain or stiffness | | | |
| Pain between shoulders | | | |
| Pain or numbness in: | | | |

| EYES, EARS, NOSE & THROAT | O | F | C |
|---|---|---|---|
| Asthma | | | |
| Colds | | | |
| Crossed eyes | | | |
| Deafness | | | |
| Dental decay | | | |
| Earache | | | |
| Ear discharge | | | |
| Ear noises | | | |
| Enlarged glands | | | |
| Enlarged thyroid | | | |
| Eye pain | | | |
| Failing vision | | | |
| Far sightedness | | | |
| Gum trouble | | | |
| Hay fever | | | |
| Hoarseness | | | |
| Nasal Obstruction | | | |
| Near sightedness | | | |

| GASTRO-INTESTINAL | O | F | C |
|---|---|---|---|
| Belching or gas | | | |
| Colitis | | | |
| Colon trouble | | | |
| Constipation | | | |
| Diarrhea | | | |

| CARDIO-VASCULAR | O | F | C |
|---|---|---|---|
| Arteriosclerosis | | | |
| Hardening of arteries | | | |
| High blood pressure | | | |
| Low blood pressure | | | |
| Pain over heart | | | |
| Poor circulation | | | |
| Rapid heartbeat | | | |
| Slow heartbeat | | | |
| Swelling of ankles | | | |

| RESPIRATORY | O | F | C |
|---|---|---|---|
| Chest pain | | | |
| Chronic cough | | | |
| Difficult breathing | | | |
| Spitting up blood | | | |
| Spitting up phlegm | | | |
| Wheezing | | | |

| SKIN | O | F | C |
|---|---|---|---|
| Boils | | | |
| Bruise easily | | | |
| Dryness | | | |
| Hives or allergy | | | |
| Itching | | | |
| Skin eruptions (rash) | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Shoulders | ☐ ☐ ☐ | Difficult digestion | ☐ ☐ ☐ | Varicose veins | ☐ ☐ ☐ |
| Arms | ☐ ☐ ☐ | Distension of abdomen | ☐ ☐ ☐ | | |
| Elbows | ☐ ☐ ☐ | Excessive hunger | ☐ ☐ ☐ | **FOR WOMEN ONLY** | ☐ ☐ ☐ |
| Hands | ☐ ☐ ☐ | Gall bladder trouble | ☐ ☐ ☐ | Congested breasts | ☐ ☐ ☐ |
| Hips | ☐ ☐ ☐ | Hemorrhoids | ☐ ☐ ☐ | Cramps or backaches | ☐ ☐ ☐ |
| Legs | ☐ ☐ ☐ | Intestinal worms | ☐ ☐ ☐ | Excessive menstrual flow | ☐ ☐ ☐ |
| Knees | ☐ ☐ ☐ | Jaundice | ☐ ☐ ☐ | Hot flashes | ☐ ☐ ☐ |
| Feet | ☐ ☐ ☐ | Liver trouble | ☐ ☐ ☐ | Irregular cycle | ☐ ☐ ☐ |
| Painful tail bone | ☐ ☐ ☐ | Nausea | ☐ ☐ ☐ | Menopausal symptoms | ☐ ☐ ☐ |
| Poor posture | ☐ ☐ ☐ | Pain over stomach | ☐ ☐ ☐ | Painful Menstruation | ☐ ☐ ☐ |
| Sciatica | ☐ ☐ ☐ | Poor appetite | ☐ ☐ ☐ | Vaginal Discharge | ☐ ☐ ☐ |
| Spinal Curvature | ☐ ☐ ☐ | Vomiting | ☐ ☐ ☐ | Are you pregnant? | Yes ☐ |
| | | | | | No ☐ |
| Swollen Joints | ☐ ☐ ☐ | Vomiting of blood | ☐ ☐ ☐ | | |

**GENITO-URINARY**

| | |
|---|---|
| Bed-wetting | ☐ ☐ ☐ |
| Blood in urine | ☐ ☐ ☐ |
| Frequent urination | ☐ ☐ ☐ |
| Inability to control kidneys | ☐ ☐ ☐ |
| Kidney infection or stones | ☐ ☐ ☐ |
| Painful urination | ☐ ☐ ☐ |
| Prostate trouble | ☐ ☐ ☐ |
| Pus in urine | ☐ ☐ ☐ |

## CIRCLE THE FOLLOWING CONDITIONS YOU HAVE HAD

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Diabetes | ☐ Influenza | ☐ Polio |
| ☐ Anemia | ☐ Eczema | ☐ Malaria | ☐ Rheumatic fever |
| ☐ Appendicitis | ☐ Emphysema | ☐ Measles | ☐ Scarlet fever |
| ☐ Arteriosclerosis | ☐ Epilepsy | ☐ Miscarriage | ☐ Stroke |
| ☐ Arthritis | ☐ Fever blisters | ☐ Multiple sclerosis | ☐ Tuberculosis |
| ☐ Cancer | ☐ Goiter | ☐ Mumps | ☐ Typhoid fever |
| ☐ Chorea | ☐ Gout | ☐ Pleurisy | ☐ Ulcers |
| ☐ Cold Sores | ☐ Heart disease | ☐ Pneumonia | ☐ Whooping Cough |

What's your major complaint? _____

Surgical operations & years? _____

Medicine Now: ☐ Nerve pills ☐ Painkillers ☐ Muscle relaxers ☐ Pep pills ☐ Tranquilizers ☐ Birth Control

Others:

_____

Age of Mattress: _____ ▢ Comfortable ▢ Uncomfortable. ▢ Do you use a bed board?

Describe:

---

Are you wearing: ▢ Heel lifts ▢ Sole lifts ▢ Inner soles ▢ Arch supports? _____

Have you been in an auto accident: ▢ Past year ▢ Past five years ▢ Over five years ▢ Never?

Describe: _____

Have you ever had any mental or emotional disorders? ▢ Yes ▢ No When? _____

Have any others in your family had such disorders? ▢ Yes ▢ No When? _____

| **Have you ever:** | **YES** | **NO** | **BRIEF DESCRIPTION** |
|---|---|---|---|
| Been knocked unconscious? | ☐ | ☐ | |
| Used, a cane, crutch, or other? | ☐ | ☐ | |
| Been treated for a spine or nerve disorder? | ☐ | ☐ | |
| Had a fractured bone? | ☐ | ☐ | |
| Hospitalized other than surgery? | ☐ | ☐ | |

| **DATE OF LAST:** | **Less than 6 months** | **6-18 months** | **Over 18 months** | **Never** |
|---|---|---|---|---|
| Spinal examination | ☐ | ☐ | ☐ | ☐ |
| Physical examination | ☐ | ☐ | ☐ | ☐ |
| Blood test | ☐ | ☐ | ☐ | ☐ |
| Chest X-ray | ☐ | ☐ | ☐ | ☐ |
| Spinal X-ray | ☐ | ☐ | ☐ | ☐ |
| Dental X-ray | ☐ | ☐ | ☐ | ☐ |
| Urine test | ☐ | ☐ | ☐ | ☐ |

| **HABITS** | **Heavy** | **Moderate** | **Light** | **None** |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |

IN CASE OF EMERGENCY:

NAME: _____

Phone Number: _____

# Office Financial Policy

### Private Pay

1. All patients are on a private pay basis regardless of each individual's respective insurance coverage and deductible.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

### Insurance

1. If you have insurance, we will not accept assignment; however, we will make every effort to provide proper documentation for your personal submission with your insurance provider.

2. Should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company. We will not enter any dispute with it, as your contract is between you and your insurance company.

3. Any and all services are due at time of service and are the patient's responsibility.

4. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full is due immediately.

5. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor. Thank You

**I have read and understand the Financial Office Policy and agree to abide by these terms.**

_____ _____

Patient's Signature Date