Sunshine Chiropractic Center

3436 N. Andrews Ave
Oakland Park, Fl. 33309

Dr. Beth Cooper

WELCOME TO OUR OFFICE! YOU ARE SPECIAL AND WE THANK YOU FOR YOUR TRUST!

Date:_____

PATIENT INTRODUCTION CARD

File No.:_____

1. Name (last, first, middle):

_____

2. Address (street, city, state, zip):

_____

_____

3. Telephone: (cell)_____

4. Employer's Name and Address:_____

_____

_____

5. Work Telephone: _____

6. Date of birth: _____

7. How young are you? _____

8. Social Security No.:_____

9. ☐ Male ☐ Female

10. ☐ Married ☐ Single

Spouse's Name: _____

11. No. of Children: _____

12. Is it possible you are pregnant? ☐ Yes ☐ No

13. Referred by: _____

Email Address_____

14. Describe your problem. (How and when do you think it started?) _____

_____

_____

15. Have you had a prior diagnosis about this? ☐ Yes ☐ No What_____

16. Have you had other diagnostic problems? _____

17. Have you had chiropractic care before? ☐ Yes ☐ No
Where?_____ When _____

18. Do you have Health Insurance? ☐ Yes ☐ No Company _____

19. Are you here due to: ☐ wellness care ☐ an on the job injury ☐ auto accident

20. Have you ever had any falls, auto accidents or injuries? ☐ Yes ☐ No
When Type of Accident Describe

_____

_____

21. Decribe any surgery you have had (when and what type) _____

_____

22. List any present medications and why you are taking them:_____

_____

Over Please..

PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

Muscle / Joint

O	F	C	
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain, stiffness
☐	☐	☐	Pain between shoulders

General

O	F	C	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness, depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

Cardiovascular

O	F	C	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heartbeat
☐	☐	☐	Slow heartbeat
☐	☐	☐	Swelling of ankles

Genitourinary

O	F	C	
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Lack of kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

Eye, Ear, Nose and Throat

O	F	C	
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noise
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

Gastrointestinal

O	F	C	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Bloated abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gallbladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

Skin

O	F	C	
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

Pain or numbness in

O	F	C	
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hand
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

Respiratory

O	F	C	
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

Women only

O	F	C	
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopause
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Please mark your areas of pain on the figures below.