SUNSHINE CHIROPRACTIC CENTER

3436 NORTH ANDREWS AVE
OAKLAND PARK FLORIDA 33309

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DR. BETH COOPER
954-390-0818

Today's date:									
PATIENT INFORMATION									
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid/ Domestic Partner				
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:				
❑ Yes ❑ No			/ /		❑ M ❑ F				
Street address:	Social Security no.:	Home phone no.:							
		( )							
Cell Phone #:	City:	State:	ZIP Code:						
Occupation:	Employer:	Employer phone no.:							
		( )							
Referred by:	❑ Dr.		❑ Insurance Plan	❑ Hospital					
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other					
Other family members seen here:									

Your email address:_____ DO YOU PREFER: EMAIL PHONE TEXT

Describe your chief complaint or problem _____

_____

_____

Have you had a prior diagnosis? _____

Do you have any other health problems or conditions?_____

Have you had chiropractic care before?? YES / NO Why did you stop:_____

Do you have health insurance? YES / NO NAME OF INSURER:_____

Are you here due to: _____wellness care _____on the job injury _____auto accident

Have you ever had any falls, auto accidents or injuries?? YES / NO WHEN?_____

Describe any surgeries you have had:_____

_____

List all medications/supplements and why you are taking them: _____

_____

Date (s) of Accident	Type of Accident(s)	Injuries Sustained

What is your understanding of chiropractic? **NONE - SOME - A LOT**

Do you know anybody who could benefit from Chiropractic Care?_____

Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	☐	☐	_____
... had any mental disorders?	☐	☐	_____
... had any broken bones?	☐	☐	_____
... had any strains or sprains?	☐	☐	_____
... ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain
- ☐ Elbow ☐ Wrist
- ☐ Plantar Fasciitis
- ☐ TMJ/jaw issues
- ☐ Midback/Thoracic pain
- ☐ Thumb pain ☐ Toe pain
- ☐ Finger
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Shoulder

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: _____

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness ☐ Itching
- ☐ Hives or allergies ☐ Rash
- ☐ Varicose veins

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why: