Print Form

Clear Form Data

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Fort Myers Chiropractic Studio
Dr. Christine Hoch, D.C.
12655 New Brittany Blvd. #13W
Fort Myers, FL 33907
1 (239) 243-8735

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender ○ Male ○ Female

Nickname

Address of Permanent Residence

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

Ethnicity

City

State/Province

ZIP/Postal Code

Seasonal Address

Spouse's Name

City

State/Province

ZIP/Postal Code

Children's names and Ages

Home Phone

Cell Phone

Are you Medicare eligible? ☐ Yes ☐ No

If Yes, please present your Medicare card at the front desk, and please read our Special Notice to Medicare Patients. (Medicare replacement policies are not the same as Medicare)

Email Address

Emergency Contact

Emergency Contact's Phone

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City

State/Province

ZIP/Postal Code

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Request for Confidential Communication and Use of Email

Our office uses text messaging, as well as email to contact our patients regarding care, appointment reminders, holiday closures, or other announcements pertinent to our office.

Please read and complete the required areas to the right advising how you would prefer we disclose detailed and/or potentially sensitive information to you in the event we must contact you.

You may..

contact me via home and/or cell phone	☐ Yes	☐ No
leave a detailed message on my home answering	☐ Yes	☐ No
machine leave a detailed message on my cell phone	☐ Yes	☐ No
contact me via text message	☐ Yes	☐ No
mail correspondence to my home address	☐ Yes	☐ No
leave a detailed message with someone I trust	☐ Yes	☐ No

If yes, who: Relationship: Phone #:

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

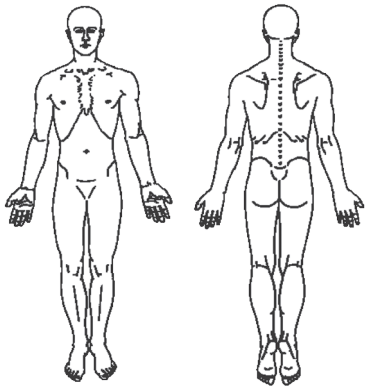
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should Dr. Hoch know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

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Dr. Christine Hoch, D.C.

(Continued from previous page)

h. Endocrine

Had Have ◯ ◯ Thyroid issues | Had Have ◯ ◯ Immune disorders | Had Have ◯ ◯ Hypoglycemia | Had Have ◯ ◯ Frequent infection | Had Have ◯ ◯ Swollen glands | Had Have ◯ ◯ Low energy | NONE ◯ Initials ____

i. Genitourinary

Had Have ◯ ◯ Kidney stones | Had Have ◯ ◯ Infertility | Had Have ◯ ◯ Bedwetting | Had Have ◯ ◯ Prostate issues | Had Have ◯ ◯ Erectile dysfunction | Had Have ◯ ◯ PMS symptoms | NONE ◯ Initials ____

j. Constitutional

Had Have ◯ ◯ Fainting | Had Have ◯ ◯ Low libido | Had Have ◯ ◯ Poor appetite | Had Have ◯ ◯ Fatigue | Had Have ◯ ◯ Sudden weight gain/loss (circle one) | Had Have ◯ ◯ Weakness | NONE ◯ Initials ____

Patient name _____

Patient Number (office use only) _____

◯ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Clear Illness Selections

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
◯	◯	AIDS	◯	◯	Tuberculosis
◯	◯	Alcoholism	◯	◯	Typhoid fever
◯	◯	Allergies	◯	◯	Ulcer
◯	◯	Arteriosclerosis	◯	◯	Other: _____
◯	◯	Cancer			
◯	◯	Chicken pox			
◯	◯	Diabetes			
◯	◯	Epilepsy			
◯	◯	Glaucoma			
◯	◯	Goiter			
◯	◯	Gout			
◯	◯	Heart disease			
◯	◯	Hepatitis			
◯	◯	HIV Positive			
◯	◯	Malaria			
◯	◯	Measles			
◯	◯	Multiple Sclerosis			
◯	◯	Mumps			
◯	◯	Polio			
◯	◯	Rheumatic fever			
◯	◯	Scarlet fever			
◯	◯	Sexually transmitted disease			
◯	◯	Stroke			

17. Allergies

Are you allergic to any medications?

Yes ◯ No ◯ If Yes please list: _____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery: _____
- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine _____
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: _____

16. Treatments

Clear Treament Selections

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy
◯	◯	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

18. Injuries

Have you ever...

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

Consultation Notes

19. Family History

Clear Family History Data

Some health issues are hereditary. Tell Dr. Hoch about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		◯	◯			◯	◯
Father		◯	◯			◯	◯
Sister 1		◯	◯			◯	◯
Sister 2		◯	◯			◯	◯
Brother 1		◯	◯			◯	◯
Brother 2		◯	◯			◯	◯
_____		◯	◯			◯	◯

20. Are there any other hereditary health issues that you know about? _____

21. Social History

Clear Social History Data

Tell Dr. Hoch about your health habits and stress levels.

SOCIAL

Alcohol use	◯ Daily	◯ Weekly	How much? _____	Prayer or meditation?	◯ Yes	◯ No
Coffee use	◯ Daily	◯ Weekly	How much? _____	Job pressure/stress?	◯ Yes	◯ No
Tobacco use	◯ Daily	◯ Weekly	How much? _____	Financial peace?	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How much? _____	Vaccinated?	◯ Yes	◯ No
Pain relievers	◯ Daily	◯ Weekly	How much? _____	Mercury fillings?	◯ Yes	◯ No
Soft drinks	◯ Daily	◯ Weekly	How much? _____	Recreational drugs?	◯ Yes	◯ No
Water intake	◯ Daily	◯ Weekly	How much? _____			

Hobbies: _____

Doctor's Initials _____

Fort Myers Chiropractic Studio
Dr. Christine Hoch, D.C.

22. 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	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

23. What is the major stressor in your life? _____

24. How much sleep do you average per night? _____ **Hours**

25. What is the type and approximate age of your mattress and pillow? _____

26. What is your preferred sleeping position? _____

27. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

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

29. In addition to the main reason for your visit today, what additional health goals do you have? _____

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.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **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.**

Initials ____ **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):** _____

Initials ____ **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.**

Initials ____ **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.**

If the patient is a minor child, print child's full name: _____

Signature _____ Date (MM/DD/YYYY) _____

Print Form

Patient name _____

Patient Number
(office use only)

Consultation Notes

Doctor's Initials _____

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