Port Orange Family Chiropractic Center

4606 Clyde Morris Blvd., #1M
Port Orange, FL 32129
www.portorangefamilychiropracticcenter.com
756-9303

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:_____ Today's Date:_____

Address:_____

City:_____ State:_____ ZIP:_____

Phone Home:_____ Work:_____ Fax:_____ Cell:_____

E-Mail:_____

Marital status:☐Married ☐Divorced ☐Single ☐Widow ☐Widower

Birthdate:____/_____/_____ Age:_____ Social Security #:_____

Who may we thank for referring you?_____

Your prior doctor of chiropractic and address:_____

Chiropractic techniques you've had success with:_____

Last time you went to previous Doctor of Chiropractic:_____

General Practitioner:_____ and City:_____

Your employer:_____ Phone Number:_____

Employer's address:_____

Occupation:_____

Spouse's name:_____

Spouse's employer:_____

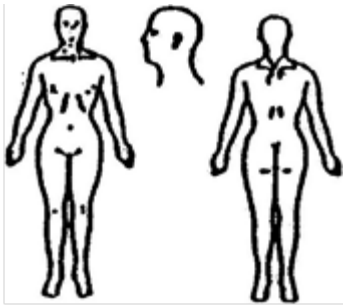
Children's names & ages:_____

_____

Favorite hobbies or interests:_____

_____

Mark Area (s) of Health Concerns



Method of payment for first visit:

☐Cash ☐Check ☐M/C ☐Credit Card

Health reasons for consulting our office:

1._____ 3._____

2._____ 4._____

Have you had same or similar problem(s)before? ☐Yes ☐No If so, how long? _____

Please Explain:_____

_____

☐Father ☐Mother ☐Brother ☐Sister ☐Children, with similar problems?

_____

Is this the result of an auto or work injury? ☐Yes ☐No If so, when?_____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

_____

Other doctors who have treated this problem:_____

_____

Surgery you have had:_____

_____

Medication(s) you currently take:_____

_____

Is there any chance you are pregnant? ☐Yes ☐No

What have you heard about chiropractic care?_____

_____

Do you know what a subluxation is? ☐Yes ☐No If yes, please describe:

_____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer? ☐Yes ☐No If so, what type?

_____

Do you have health insurance? ☐Yes ☐No Name of Company:_____

Medicare: ☐Yes ☐No Medicaid: ☐Yes ☐No

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____Date:_____

PORT ORANGE FAMILY CHIROPRACTIC CENTER

PATIENT'S NAME: _____ HR#: _____ DATE: _____

ACTIVITIES OF LIFE

Please check how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Lifting/Carry Children	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shopping/ Carry Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Oral Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Toileting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ DATE: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date**
Form Reviewed

Port Orange
Family Chiropractic Center

Dr. Mindy A. Weingarten
Dr. Terry L. Kahn

4606 Clyde Morris Blvd • Suite 1M • Port Orange, FL 32129
(386) 756-9303 • Fax (386) 756-8119

Instructions For First Visit

1) No Heels, Flip Flops, or Sandals.
Please Wear Closed Shoes/Sneakers
For All Of Your Visits.

2) No Scented Products
For All Of Your Visits.
(Perfumes, colognes, body sprays,
lotions, powders or oils)

3) No Belts

4) No Metal. Jewelry or Adornments
On Clothes
(earrings, necklaces, buttons,
rhinestones, bling)