



STEVENS CHIROPRACTIC & WELLNESS CENTER

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Your Last Name		Your Social Security Number	Birth Date (MM/DD/YYYY)	Age
Your First Name		Your Middle Name (or Initial)	Gender <input type="radio"/> Male <input type="radio"/> Female	Race
Address		Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated		Ethnicity
City	State/Province	ZIP/Postal Code		Preferred Language
Home Phone	Cell Phone	Spouse's Name		
Email Address	Child's Name and Age			
Emergency Contact	Emergency Contact's Phone	Child's Name and Age		
Your Occupation	Child's Name and Age			
Your Employer	Work Phone			
Address		May we contact you at work? <input type="radio"/> Yes <input type="radio"/> No		
City	State/Province	ZIP/Postal Code		Preferred method of contact? <input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email
Primary Care Provider's Name				

UPDATED CONTACT INFORMATION

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

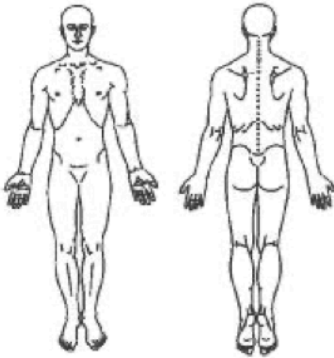
I have new contact information

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.
- New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.
- Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



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

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

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



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

Constant Come and goes.

When did it start and how often? _____

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

6. 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? _____

7. 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

8. What else should we know about your current condition?

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

11. Medications (please list all prescription and over-the-counter): _____

12. Social History (Tell us about your health habits and stress levels)

Alcohol use Daily Weekly How much? _____
Coffee use Daily Weekly How much? _____
Tobacco use Daily Weekly How much? _____
Exercising Daily Weekly How much? _____
Pain relievers Daily Weekly How much? _____
Soft drinks Daily Weekly How much? _____
Water intake Daily Weekly How much? _____
Hobbies: _____

Prayer or meditation? Yes No
Job pressure/stress? Yes No
Financial peace? Yes No
Vaccinated? Yes No
Mercury fillings? Yes No
Recreational drugs? Yes No

13. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Is there anything else we should know about your current condition, your progress or ways your current condition is affecting your life?

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)

Stevens Chiropractic & Wellness Center
14090 Metropolis Ave. Suite 101
Fort Myers, FL 33912
239-489-4100