UPDATED CONTACT INFORMATION

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

Serenity Health Chiropractic
April Lee, DC, CPCO, CPMA
60 2nd St., Unit C-7
Shalimar, FL 32579
PH: 850-613-4125
Fax: 850-613-4148
bluewaterchiropractic.com

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

Patient Number (office use only) ____________

Age ____________

Gender
○ Male ○ Female

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Birth Date (MM/DD/YYYY) ____________

Your Last Name ____________

Your Social Security Number ____________

Smoking Status (age 13 and over)
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

Your First Name ____________

Your Middle Name (or Initial) ____________

Address ____________

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

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?
○ Yes ○ No

City ____________ **State/Province** ____________ **ZIP/Postal Code** ____________

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

Primary Care Provider's Name ____________

Insurance Carrier ____________ **Policy Number** ____________

Insured's Last Name ____________ **Birth Date (MM/DD/YYYY)** ____________

Who carries this policy?
○ Self ○ Spouse ○ Parent

Insured's First Name ____________ **Insured's Middle Name (or Initial)** ____________

Insured's Employer ____________

Address ____________

City ____________ **State/Province** ____________ **ZIP/Postal Code** ____________ **Employer's Phone** ____________

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

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UPDATED PATIENT HISTORY

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◯ **I have new contact information**

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

Patient Number (office use only) ______________

Your Last Name ______________ **Your First Name** ______________ **Your Middle Name (or Initial)** ______________

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.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ______________

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

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

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ______________

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

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

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

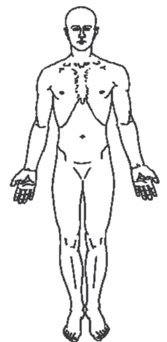
Additional Complaint
The additional symptom that prompted me to seek care today is: ______________

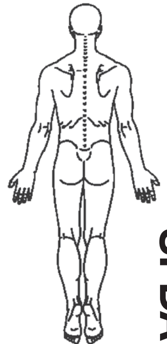
And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other ______________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ______________

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

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

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





UPDATED PATIENT HISTORY

1. 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.	◯	◯	◯
b. **Neurological System** – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. **Cardiovascular System** – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. **Respiratory System** – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. **Digestive System** – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. **Sensory System** – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. **Skin System** – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. **Endocrine System**– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. **Genitourinary System** – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. **Constitutional System** – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

Doctor's Initials ______________

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2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: ______________________

____

____

3. Medications (please list all prescription and over-the-counter): ______________________

____

____

4. Social History (Tell Dr. Lee 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

5. 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	◯	◯	◯	◯

6. Is there anything else Dr. Lee should know about your current condition, your progress or ways your current condition is affecting your life?

____

______________________ Patient (or Guardian's) signature

______________________ Date (MM/DD/YYYY)

______________________ **Patient name**

______________________ **Patient Number**
(office use only)

Consultation Notes

UPDATED PATIENT HISTORY

______________________ **Doctor's Initials**

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