CHERY CHIROPRACTIC CENTER
CARINE CHERY, D.C.
1900 CRYSTAL DRIVE, STE.1
FORT MYERS, FL 33907
TELEPHONE: (239) 936 6566
FAX: (239) 936 6442
Email: cherychiro@yahoo.com

NAME: _____ DATE: _____

ADDRESS: _____CITY:_____

STATE: _____ ZIP CODE: _____

HOME PHONE: _____CELL PHONE: _____

OCCUPATION: _____ COMPANY NAME: _____

EMAIL ADDRESS: _____

SEX: MALE: _____ FEMALE: _____ DATE OF BIRTH: ___/____/_____

SINGLE: _____ MARRIED: _____ SEPARATED: _____ DIVORCED: _____

HEIGHT: _____ WEIGHT: _____

SOCIAL SECURITY NUMBER: _____

Who referred you to us? _____

How else did you hear about us? : _____

PRIMARY CARE MEDICAL DOCTOR: _____
PRIOR CHIROPRACTIC CARE: ( ) Yes ( ) No

CHECK YOUR PRESENT COMPLAINTS:
( ) Neck Pain/Stiffness/ Spasms: ( ) Right ( ) Left ( ) Both sides
( ) Upper back and Shoulders: ( ) Right ( ) Left ( ) Both sides
( ) Mid Back Pain/Stiffness/Spasms: ( ) Right ( ) Left ( )Both sides
( ) Low Back Pain/Stiffness/ Spasms: ( ) Right ( ) Left ( ) both sides
( ) Headaches: ( ) Back of head ( ) Top of Head ( ) Right side ( ) Left Side ( ) Front
( ) Arm/Hand/Finger Numbness/ Tingling: ( ) Right ( ) Left ( ) Both Sides
( ) Buttock/Leg/Foot/Toe Numbness/Tingling: ( ) Right ( ) Left ( ) Both Sides
( ) Knee/Hip Pain: ( ) Right ( ) Left ( ) both sides
( ) Arm/Shoulder Pain: ( ) Right ( ) Left ( ) both sides
( ) Other Complaints:_____

DATE YOUR SYMPTOMS STARTED: _____

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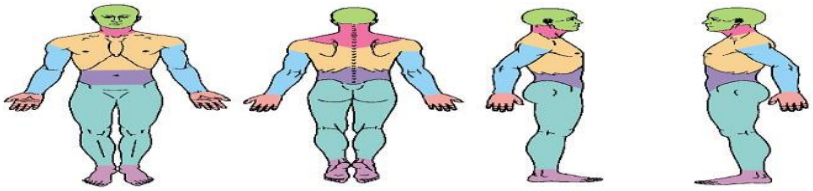
Mark on the picture where you hurt: How bad is your pain? From a scale of 1 to 10

**<---------->
1(no pain) 2 3 4 5 6 7 8 9 10 (severe)**



Front back right left

How long have you had this condition? _____

Have you had this or similar condition in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ( ) Improved ( ) Unchanged ( ) Getting Worse

Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine Other_____

WHAT CAUSED YOUR PRESENT COMPLAINTS?

( ) Unknown ( ) Auto Accident ( ) Work Injury ( ) Personal injury ( ) Other

EXPLAIN:_____

_____

PAST ACCIDENTS/INJURIES: ( ) YES ( ) NO

( ) Auto Accidents: Date: _____( ) Work Injuries: Date: _____

( ) Personal Injuries: Date: _____

EXPLAIN:_____

DO YOU HAVE A PERMANENT INJURY/DISABILITY? ( ) YES ( ) NO

If yes, where is your permanent injury located? _____

What is your impairment/disability rating? _____

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MEDICATIONS:

1. **List regular medications that you take:**_____
   _____

2. **List regular over the counter medications that you take:**_____
   _____

DIET AND EXERCISE:

1. **Do you smoke? ( ) Never ( ) Former Smoker ( ) Current/Every Day Smoker**
2. **Do you exercise regularly? # of times weekly: 0 - 1- 2- 3- 4- 5- 6- 7**

ALLERGIES:

1. **Have you been diagnosed with any allergies? ( ) Food ( ) Environmental ( )Medication**

   If yes, please list allergy and reaction _____

HEALTH HISTORY:

1. **Have you been hospitalized in the last 5 years? ( ) Yes ( ) No**
2. **Date you were hospitalized:** _____
3. **Have you been diagnosed with Diabetes? ( ) Yes ( ) No**
   ( ) Type I ( ) Type II
4. **Have you been treated for hypertension? ( ) Yes ( ) No**

CANCER:

1. **Has a physician ever diagnosed you with cancer? ( ) Yes ( ) No**
   If yes, what is the name of the cancer? _____

CARDIOPULMONARY AND CIRCULATORY HEALTH:

1. **Has a physician ever diagnosed you with any heart, lung or circulation disorder? ( ) Yes ( ) No**
   If yes, what is the name of the disorder? _____

EMOTIONAL AND MENTAL HEALTH:

1. **Has a physician ever diagnosed you with any emotional or mental health disorder? ( ) Yes ( ) No If yes, what is the name of the disorder?** _____

SENSORY HEALTH:

1. **Has a physician ever diagnosed you with any sensory disorder? ( )Yes ( ) No**
   If yes, what is the name of the disorder? _____

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MUSCULOSKELETAL HEALTH:

1. **Has a physician ever diagnosed you with any muscular or spinal disorder? ( ) Yes ( ) No**
   If yes, what is the name of the disorder? _____

REPRODUCTIVE HEALTH:

1. **Has a physician ever diagnosed you with any reproductive disorder/ dysfunction? ( )Yes ( )No**
   If yes, what is the name of the disorder? _____

FEES ARE PAYABLE AT THE TIME SERVICES ARE PERFORMED UNLESS OTHER ARRAGEMENTS ARE MADE: X-RAYS ARE THE PROPERTY OF THIS CLINIC.
HOW WILL PAYMENT BE MADE: ( ) Cash ( ) Check ( ) Credit Card
( ) Health Insurance ( ) Auto Insurance ( ) Work Comp.
NAME OF INSURANCE COMPANY: _____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature_____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature_____

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INFORMED CONSENT TO CHIROPRACTIC CARE

Patient: Please discuss any questions or concerns with Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

- Chiropractic Adjustment
- Electrical Muscle Stimulation
- Therapeutic Exercises
- Manual Therapy
- Extremity Manipulation
- Ultrasound
- Hot Pack/Cold Pack
- Mechanical Traction

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized, I have had the opportunity to read this form and this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Patient/Guardian _____ Date _____

(If patient is a minor)

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IMPORTANT: Please check (X) all present symptoms

Head:

- ☐ Headache
  - Sinus (allergy)
  - Entire Head
  - Back of Head
  - Forehead
  - Temples
  - Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-Headedness
- ☐ Fainting
- ☐ Light bother eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

Neck:

- ☐ Pain in neck
- ☐ Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

Arms and Hands;

- ☐ Pain in upper arm/elbow
- ☐ Loss of grip strength
- ☐ Aggravated by movement
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arms
- ☐ Sensation of pins and needles in fingers
- ☐ Swollen joints in fingers
- ☐ Numbness in arms (R / L)
- ☐ Fingers go to sleep

Shoulders:

- ☐ Pain in shoulder joint (R / L)
- ☐ Pain across shoulders
- ☐ Bursitis (R / L)
- ☐ Arthritis (R / L)
- ☐ Can't raise arm above shoulder
- ☐ Can't raise arm over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R / L)
- ☐ Muscle spasms in shoulders

Mid Back:

- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscles spasms
- ☐ Pain in kidney area

Chest:

- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Irregular heartbeat

Abdomen:

- ☐ Nervous stomach
- ☐ Can't eat certain food
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

Low Back:

- ☐ Low back pain
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasm
- ☐ Arthritis
- ☐ Worse when working
- ☐ Worse with lifting
- ☐ Worse with standing
- ☐ Worse with sitting
- ☐ Worse with bending
- ☐ Worse with coughing
- ☐ Worse with lying down/sleeping
- ☐ Worse with walking
- ☐ Diabetes

( ) Hands cold ( ) Swollen joints in fingers

Hips, Legs, and Feet:

- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg(s)
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Cramps in feet
- ☐ Pins/needles
- ☐ Leg numbness
- ☐ Toes numbness
- ☐ Cold feet
- ☐ Swollen ankles
- ☐ Swollen feet

Women Only:

- ☐ Menstrual pain where _____
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____days
- ☐ Birth control type _____
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors
- ☐ Abortions
- ☐ Pregnant

Men Only:

- ☐ Urinary freq.
- ☐ Difficulty w/start
- ☐ Night urination
- ☐ Prostate prob.

General:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Normal sleep
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Gain weight
- ☐ Coffee_____
- ☐ Tea _____
- ☐ Cigarettes _____
- ☐ Other _____
- ☐ Hypoglycemia

Patient's Signature: _____ Date:_____

Patient Name :_____