CULLEN CHIROPRACTIC & WELLNESS

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Patient Info Card — Welcome to our Office!

Date ____________________

Name ______________________________ Date of Birth ________________ Age ________

Cell phone ____________________ Home ____________________ Work ____________________

❑ M ❑ F E-mail ______________________________ **Preferred**: ❑Home ❑Work ❑ Mobile ❑ Email

Social Security # ________-________-__________ ❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Address ______________________________ City ____________________ State________ Zip ________________

In case of emergency, contact

Name ______________________________ Phone____________________ Relationship ______________________________

EMPLOYMENT

Current Status: ❑Employed ❑Full Time Student ❑Part Time Student ❑Retired ❑Unemployed

Employer ____

Street Address______________________________ City____________________ State______ Zip ______________

Job Title ____________________ Job Duties ____

Primary Care Physician ____

Address ______________________________ City ____________________ St __________ Zip ______________

Phone ____________________ Fax ____________________ Email ______________________________

When was your last medical exam? ____

MEDICAL HISTORY

Hospitalizations ____

Surgeries ____

Accidents or Injuries in the past year ____

in the past 1-10 years ____

in the past 11-20 years ____

Ongoing Illness ____

Check any MEDICATIONS you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

(check all that apply)	OTC	Rx		(check all that apply)	OTC	Rx		(check all that apply)	OTC	Rx
Headaches	❑	❑		Diabetes	❑	❑		Bowels/Laxative	❑	❑
Pain	❑	❑		Water Pills	❑	❑		Hormones	❑	❑
Muscle Relaxants	❑	❑		Heart/Cardiovascular	❑	❑		Thyroid	❑	❑
Arthritis	❑	❑		Blood Pressure	❑	❑		Antibiotics	❑	❑
Steriods	❑	❑		Cholesterol	❑	❑		Birth Control	❑	❑
Sinus/Allergy	❑	❑		Ulcers	❑	❑		Heartburn/Stomach	❑	❑
Asthma/Bronchitis	❑	❑		Depression/Anxiety	❑	❑		Other ________________	❑	❑
Sleeping	❑	❑		Psychological	❑	❑		NOT TAKING Medications	❑	❑

Any additional medications? ____

Patient Name ____ Date ______________

Family/Social History

Is there a family history of any of the following conditions (indicate family member including parents, grandparents and siblings)

❑ heart disease ______________________ ❑ hypertension ______________________

❑ cancer ______________________ ❑ diabetes ______________________

❑ arthritis ______________________ ❑ other ______________________

Social History:

Cigarettes/Tobacco ❑ none ❑ in the past ❑ currently ______ packs/day

Alcohol ❑ none ❑ in the past ❑ currently ______ drinks/week

How would you rate your stress level? ❑ Low ❑ moderate ❑ very stressful ❑ other ______________

Previous Tests ____

Medical Procedures ____

Dietary Habits

Diet Food Products	❑ daily	❑ weekly	❑ occasionally	❑ never
Soft Drinks	❑ daily	❑ weekly	❑ occasionally	❑ never
Fresh/homemade foods	❑ daily	❑ weekly	❑ occasionally	❑ never
Preprocessed/packaged/restaurant food	❑ daily	❑ weekly	❑ occasionally	❑ never
Water	❑ daily	❑ weekly	❑ occasionally	❑ never
Caffeine Drinks/Products	❑ daily	❑ weekly	❑ occasionally	❑ never

Nutritional Supplements

Energy Products	❑ daily	❑ weekly	❑ occasionally	❑ never
Over-the-counter stimulants	❑ daily	❑ weekly	❑ occasionally	❑ never

Sleep: what is the average number of hours you sleep per night? ______________

Do you wake up feeling: ❑ tired/un-rested ❑ awake and ready for the day ❑ other ______________________

Exercise: ❑ None ❑ yes, average ______ times per week.

Type of exercise ____

Hobbies: what do you do for relaxation and fun? ____

____

Previous chiropractic care? ❑ No ❑ Yes Dr. ______________ When/where? ______________________

Whom may we thank for referring you? ____

Is the condition you are here for today a result of: ❑ Employment ❑ Auto Accident / Personal Injury Case ❑ Other ______________________

Are you interested in learning more about:

❑ Weight loss
❑ Nutritional supplements
❑ Essential oils
❑ At-Home Exercises for your condition
❑ Manual Therapy
❑ Acupuncture
❑ Workshops
❑ Other ______________________

Patient Name ______________________________ Date ______________

REVIEW OF SYSTEMS (check all that apply)

General
- ❑ Chills
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Sweats

Genito-Urinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Eyes
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Vision - Flashes
- ❑ Vision - Halos
- ❑ Blurred vision

Ears/Nose/Throat
- ❑ Earache
- ❑ Ear Discharge
- ❑ Loss of hearing
- ❑ Nose bleeds
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Persistent cough

Respiratory
- ❑ Cough
- ❑ Congestion
- ❑ Distress
- ❑ Sputum
- ❑ Shortness of breath

Endocrine
- ❑ Weight gain
- ❑ Weight loss
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Hair Changes
- ❑ Extreme Thirst

Gastrointestinal
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting no blood
- ❑ Vomiting with blood

Cardiovascular
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Men only
- ❑ Breast lumps
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Prostate Problem
- ❑ Other __________

Women Only
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lumps
- ❑ Miscarriage
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Vaginal Infections
- ❑ Date of last menstrual period ____________
- ❑ Date of last pap smear____________
- ❑ Have you had a mammogram? ______
- ❑ Are you pregnant? ___
- ❑ Number of children ___
- ❑ Other ___________

Integumentary (skin)
- ❑ Bruise easy
- ❑ Hives
- ❑ Change in moles
- ❑ Sores that won't heal
- ❑ Itching
- ❑ Unusual swelling
- ❑ Sores/ulcers
- ❑ Rash
- ❑ Scars

Neurological
- ❑ Seizures
- ❑ Vertigo
- ❑ Dizziness
- ❑ Hand Trembling
- ❑ Loss of Sensations
- ❑ Loss of facial expression
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Difficulty of Speech
- ❑ Tingling
- ❑ Numbness
- ❑ Un-coordination

Psychiatric
- ❑ Hyperventilation
- ❑ Insecurity
- ❑ Trouble Sleeping
- ❑ Irritable
- ❑ Undecidedness
- ❑ Timid
- ❑ Hallucinations
- ❑ Loss of Memory
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Drug Dependency
- ❑ Extreme Worry
- ❑ Sexual Problems
- ❑ Suicidal Thoughts

Conditions
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Other ___________

Are you a full-time Florida resident? ❑ Yes ❑ No, I am a seasonal resident from ________________ staying in Florida __________ months

Signature ______________________________________ Date ____________________

FOR OFFICE USE ONLY:

Std	Medicare Modifier	Procedure	Units
❍ 98940	AT	CMT 1-2 regions	
❍ 98941	AT	CMT 3-4 regions	
❍ 98942	AT	CMT 5 regions	
❍ 98943	AT	CMT Extremity	
❍ G0283		Elec Stim other than Wound	
❍ 97010		Hot/Cold	
❍ 97012	59	MACHINICAL Traction	
❍ 29852		Pneumatic Leg Compression	
❍ 97530		Therapeutic Activities	
❍ A4452		Rocktape Application	

Std	Medicare Modifier	Procedure	Units
❍ 97810		Initial Acupuncture	1
❍ 97811		Subsequent Acupuncture	3
❍ 97140		Manual Therapy Technique	2 4 6 8
❍ 99241		Consultation: 15 Min	
❍ 99242		Consultation: 30 Min	
❍ 99243		Consultation: 40 Min	
❍ 99201	25	New Patient Exam: 5 min	
❍ 99202	25	New Patient Exam: 20 min	
❍ 99203	25	New Patient Exam: 30 min	
❍ 99204	25	New Patient Exam: 45 min	

Dx

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CULLEN CHIROPRACTIC & WELLNESS

NP Symptom Questionnaire

Patient Name ____ Date ________________

Complaint/Symptom	1.	2.	3.	4.
When did it begin? (days, weeks, months, years)				
How often does the pain/symptom occur?	Rare Occasional Frequent Constant Other	Rare Occasional Frequent Constant Other	Rare Occasional Frequent Constant Other	Rare Occasional Frequent Constant Other
Quality of the pain/ symptoms:	Dull Achy Burning Sharp Numb Tingling Stinging Shooting Spasm Stiff Pounding Constricting Other	Dull Achy Burning Sharp Numb Tingling Stinging Shooting Spasm Stiff Pounding Constricting Other	Dull Achy Burning Sharp Numb Tingling Stinging Shooting Spasm Stiff Pounding Constricting Other	Dull Achy Burning Sharp Numb Tingling Stinging Shooting Spasm Stiff Pounding Constricting Other
Does the pain/ symptom **radiate** to your:	Head Face Shoulders Arms Hands Fingers Buttocks Hip Rear thigh Front thigh Calf Shin Ankle Foot Toes Other	Head Face Shoulders Arms Hands Fingers Buttocks Hip Rear thigh Front thigh Calf Shin Ankle Foot Toes Other	Head Face Shoulders Arms Hands Fingers Buttocks Hip Rear thigh Front thigh Calf Shin Ankle Foot Toes Other	Head Face Shoulders Arms Hands Fingers Buttocks Hip Rear thigh Front thigh Calf Shin Ankle Foot Toes Other
What makes pain/ symptom **worse**?	AM PM Standing Stairs Lifting Bending Sneezing Reaching Coughing Stretching Rest Exercise Sitting Neck movement Nothing Other	AM PM Standing Stairs Lifting Bending Sneezing Reaching Coughing Stretching Rest Exercise Sitting Neck movement Nothing Other	AM PM Standing Stairs Lifting Bending Sneezing Reaching Coughing Stretching Rest Exercise Sitting Neck movement Nothing Other	AM PM Standing Stairs Lifting Bending Sneezing Reaching Coughing Stretching Rest Exercise Sitting Neck movement Nothing Other
What **relieves** the pain/symptom?	AM PM Heat Ice Rest Exercise Sitting Standing Stretching Nothing Other	AM PM Heat Ice Rest Exercise Sitting Standing Stretching Nothing Other	AM PM Heat Ice Rest Exercise Sitting Standing Stretching Nothing Other	AM PM Heat Ice Rest Exercise Sitting Standing Stretching Nothing Other
On a **scale of 1-10** (10 = worst) how bad does the pain get?	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10