CULLEN CHIROPRACTIC & WELLNESS

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Patient Info Card — Welcome to our Office!

Name _____ Date of Birth _____ Age _____

❑ M ❑ F Home Phone _____ Cell Phone _____

E-mail _____ **Preferred Method For Appt. Reminders**: ❑ Mobile ❑ Email

Social Security Number _____-_____-_____ ❑ 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 _____

Job Title _____

Street Address _____ City _____ State _____ Zip _____

PCP INFO

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 _____

Allergies _____

Medical Procedures _____

Previous Imaging (MRIs, x-rays) _____

Check any <u>MEDICATIONS</u> 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	❑	❑
Steroids	❑	❑		Cholesterol	❑	❑		Birth Control	❑	❑
Sinus/Allergy	❑	❑		Ulcers	❑	❑		Heartburn/Stomach	❑	❑
Asthma/Bronchitis	❑	❑		Depression/Anxiety	❑	❑		Other _____	❑	❑
Sleeping	❑	❑		Psychological	❑	❑		**NOT TAKING Medications**	❑	❑

Patient Name _____ Date _____

FAMILY HISTORY

Is there a family history of any of the following conditions? Please indicate family relation. (**Parents, grandparents and siblings**)

❑ Heart disease _____ ❑ Hypertension _____

❑ Cancer _____ ❑ Diabetes _____

❑ Arthritis _____ ❑ Other _____

SOCIAL HISTORY

Cigarettes/Tobacco	❑ None	❑ In the past	❑ Currently	
Alcohol Use	❑ None	❑ Light/Moderate	❑ Heavy	❑ Former Alcoholic
Activity Level (Exercise)	❑ None	❑ Light	❑ Moderate	❑ Vigorous
How would you rate your stress level?	❑ Low	❑ Moderate	❑ High	

DIETARY HABITS

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

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 _____

Patient Name _____ Date _____

REVIEW OF SYSTEMS (Check all that apply. Past and Present)

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	Procedure
❍ 98940	CMT 1 - 2 regions
❍ 98941	CMT 3 - 4 regions
❍ 98942	CMT 5 regions
❍ 98943	CMT Extremity
❍ 97140	Manual Therapy Technique
❍ 97035	Ultrasound
❍ 97012	MECHANICAL Traction
❍ G0283	Elec Stim other than Wound
❍ 97010	Hot/Cold

Std	Procedure
❍ 99202	New Patient Exam: 20 min
❍ 99203	New Patient Exam: 30 min
❍ 99204	New Patient Exam: 45 min
❍ 99241	Consultation: 15 Min
❍ 99242	Consultation: 30 Min
❍ 99243	Consultation: 40 Min
❍ 97530	Therapeutic Activities
❍ 97110	Therapeutic Exercise
❍ A4452	Rocktape Application

Dx

_____
_____
_____
_____
_____
_____
_____
_____
_____

Adjustive Techniques
- ❍ Diversified
- ❍ Directional Non-Force
- ❍ Arthostim
- ❍ Thompson
- ❍ Activator

Segments Adjusted

Cervical 1 2 3 4 5 6 7
Thoracic 1 2 3 4 5 6 7
8 9 10 11 12
Lumbar 1 2 3 4 5
Ilium Left Right
Sacrum Left Right

CULLEN CHIROPRACTIC
& WELLNESS

NP Symptom Questionnaire

Patient Name ____ Date ____________________

Complaint/Symptom Example: Low back	1.	2.	3.	4.
When did it begin? (days, weeks, months, years)				
How did it begin? Example: Exercise, car accident, etc.				
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
How often does the pain/symptom occur?	Constant Frequent Intermittent Occasional	Constant Frequent Intermittent Occasional	Constant Frequent Intermittent Occasional	Constant Frequent Intermittent Occasional
Quality of the pain/ symptoms:	Achy Dull Burning Sharp Stabbing Throbbing Stiff Constricting Tingling Numb Weak Other:	Achy Dull Burning Sharp Stabbing Throbbing Stiff Constricting Tingling Numb Weak Other:	Achy Dull Burning Sharp Stabbing Throbbing Stiff Constricting Tingling Numb Weak Other:	Achy Dull Burning Sharp Stabbing Throbbing Stiff Constricting Tingling Numb Weak Other:
Does the pain/ symptom **radiate** to your:	Head Face Neck Shoulders Arms Hands Fingers Buttocks Hip Front thigh Rear thigh Calf Shin Ankle Foot Toes Other:	Head Face Neck Shoulders Arms Hands Fingers Buttocks Hip Front thigh Rear thigh Calf Shin Ankle Foot Toes Other:	Head Face Neck Shoulders Arms Hands Fingers Buttocks Hip Front thigh Rear thigh Calf Shin Ankle Foot Toes Other:	Head Face Neck Shoulders Arms Hands Fingers Buttocks Hip Front thigh Rear thigh Calf Shin Ankle Foot Toes Other:
What makes pain/ symptom **worse**?	Activity Bending Lifting Standing Stress Twisting Movement Sitting Breathing Coughing Exercise Lying down Other:	Activity Bending Lifting Standing Stress Twisting Movement Sitting Breathing Coughing Exercise Lying down Other:	Activity Bending Lifting Standing Stress Twisting Movement Sitting Breathing Coughing Exercise Lying down Other:	Activity Bending Lifting Standing Stress Twisting Movement Sitting Breathing Coughing Exercise Lying down Other:
What **relieves** the pain/symptom?	Heat Ice Laying Meds Rest Stretching Exercise Sitting Standing Massage Other:	Heat Ice Laying Meds Rest Stretching Exercise Sitting Standing Massage Other:	Heat Ice Laying Meds Rest Stretching Exercise Sitting Standing Massage Other:	Heat Ice Laying Meds Rest Stretching Exercise Sitting Standing Massage Other: