BAILEY CHIROPRACTIC LIFE CENTER

Jason A. Bailey, D.C.
224 Southpark Circle East
St. Augustine, FL 32086
904-342-4941

Name:	☐ Male ☐ Female	Today's Date:
Address:	City/State/Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Age: Social Security#:	Date of Birth:	Marital: ☐ M ☐ S ☐ Other
Occupation:	Employer:	Name of Spouse:
Number of Children:	Ages of Children:	Email:
Insurance type: ☐ Health ☐ Medicare ☐ Medicaid ☐ Car accident ☐ Workers' Compensation ☐ Other		
Who may we thank for referring you to our office?		

Welcome to our office! Please complete all questions.

ARE YOU HERE FOR WELLNESS CARE OR FOR A SYMPTOM? ☐ Wellness ☐ Symptom

If you have a specific symptom(s), fill out this box and briefly describe each one in order of severity:

1. (Main complaint)_____

2. _____

3. _____

4. _____

5. _____

How long have you had your main complaint?_____

Have you ever had this before? ☐ Yes ☐ No When?_____

Was this related to: ☐ Auto Accident ☐ Work Accident

Have you lost work days? ☐ Yes ☐ No If so, how many?_____

HOW DO YOU WANT TO HANDLE THIS PROBLEM?

☐ Temporary relief (Help the symptom but don't fix the cause of the problem)
☐ Maximum correction (Correct the cause of the problem for maximum stability in the future)

List drugs you are currently taking(prescription and non-prescription)_____

What surgeries have you had?_____

Is there any chance you are pregnant? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what kind?_____

When did you last see a chiropractor?_____ Dr._____

What spinal maintenance programs were you given to maximize the future stability of your spine?_____

_____

Who is your primary care physician? _____ Phys. city:_____

Phys. state: _____ May we send progress note regarding your case to your physician? ☐ Yes ☐ No

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY:

☐ Headaches	☐ Depression	☐ Mid-back pain	☐ Kidney trouble
☐ Shooting head pains	☐ Dizziness	☐ Heart attacks	☐ Menstrual cramps and pain
☐ Sinus Troubles	☐ Fainting	☐ High blood pressure	☐ Menstrual irregularity
☐ Loss of smell	☐ Loss of Balance	☐ Low blood pressure	☐ Diabetes
☐ Allergies	☐ Ringing in ears	☐ Anemia	☐ Cancer
☐ Hay fever	☐ Blurred vision	☐ Stomach trouble	☐ Sleeping problems
☐ Ear Infections	☐ Light bothers eyes	☐ Nervousness	☐ Painful joints
☐ Asthma	☐ Neck Pain	☐ Inner tension	☐ Swollen joints
☐ Loss of taste	☐ Muscle spasms in neck	☐ Irritability	☐ Pinched nerves in back
☐ Tightness of throat	☐ Tightness of shoulder muscles	☐ Cold Sweats	☐ Pins and needles in legs
☐ Inflammation of throat	☐ Pain in shoulders and arms	☐ Gall bladder trouble	☐ Swollen ankles
☐ Thyroid trouble	☐ Pins and needles arms/hands	☐ Indigestion	☐ Cold feet
☐ Twitching of face	☐ Cold hands	☐ Intestinal gas	☐ Pains in legs and feet
☐ Loss of memory	☐ Chest pains	☐ Low back pain	☐ Constipation
☐ Fatigue	☐ Pain when coughing	☐ Numbness in the low back	☐ Difficulty breathing
☐ Lung problems	☐ Frequent urination	☐ Mental Disorders	☐ Excess sweating
☐ Stroke	☐ Prostate problems	☐ Dyslexia	☐ Liver problems

PATIENT SOCIAL:

Alcohol:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Drugs:**	☐Daily	☐Weekly	☐Occasionally	☐Never
OTCStimulants:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Exercise:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Homemade Food:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Processed:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Soft Drinks:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Tobacco:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Water:	☐Daily	☐Weekly	☐Occasionally	☐Never					
Caffiene:	☐Daily	☐Weekly	☐Occasionally	☐Never					

FAMILY HEALTH HISTORY: Please list diagnosed conditions and untimely deaths of family members (Family members include: Parents and siblings and paternal and maternal grandparents/uncles/aunts)

I certify that I'm the patient of legal guardian listed on this entrance form. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

Signature:_____ Date:_____