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
OTCStimulants:	☐Daily	☐Weekly	☐Occasionally	☐Never
Homemade Food:	☐Daily	☐Weekly	☐Occasionally	☐Never
Soft Drinks:	☐Daily	☐Weekly	☐Occasionally	☐Never
Water:	☐Daily	☐Weekly	☐Occasionally	☐Never
Caffiene:	☐Daily	☐Weekly	☐Occasionally	☐Never

Drugs:	☐Daily	☐Weekly	☐Occasionally	☐Never
Exercise:	☐Daily	☐Weekly	☐Occasionally	☐Never
Processed:	☐Daily	☐Weekly	☐Occasionally	☐Never
Tobacco:	☐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:__________________________________

ACCIDENT HISTORY

FULL NAME________________________ DATE ________________________

ADDRESS ________________________ PATIENT#_____________________

____

DATE OF BIRTH_____________________ DATE OF ACCIDENT____________

SS# ________________________ TIME OF ACCIDENT ____________

□ AUTO ACCIDENT

□ PERSONAL INJURY

□ WORKER'S COMPENSATION

□ OTHER __________________

If worker's compensation please complete the following
EMPLOYER __________________________
OCCUPATION ________________________
TELEPHONE#_________________________
SUPERVISOR_________________________
LENGTH OF APPOINTMENT ____________
AUTHORIZATION □ YES □ NO

HISTORY

1. Were you a □ Driver □ Passenger □ Other __________________________

2. Location of accident ____
Street City

3. Traveling or stopped facing which direction: N S E W

History of accident:
□ Stopped and rear ended □ Hit head on □ Lost control of car
□ Other car ran a stop sign or red light □ Other ________________________

Accident Description
____
____
____
____

4. Did you strike any objects in the car? □ Yes □ No
5. If yes, what did you hit?

□ Street column □ Rearview mirror □ Dashboard
□ Other ___________ □ Seat broke □ Windshield
□ Headrest □ Side window □ Door panel
□ Cannot remember ___________________

6. What portion of your body did you hit?

□ Head
□ Face
□ Arms
□ Chest
□ Knees
□ Other ___________________________

7. Were you □ Unconscious □ Cut □ Bleeding
If cut or bleeding, on what part(s) of your body
____

8. Do you have any bruises? □ Yes □ No
If yes, on what part(s) of the body?
____

9. Did you feel immediate pain? □ Yes □ No
If yes, where did you feel the pain?
□ Head □ Mid Back
□ Extremity _______________________________
□ Neck □ Low Back
□ Other __________________________________
If not, when did your pain start?
____

10. Did you or do you feel:
□ Dizzy □ Blurry Vision
□ Loss of memory □ Ringing in the ears
□ Head feels heavy □ Loss of sleep

11. Were you wearing a seat belt? □ Yes □ No

12. After the accident, did you:
□ Go home □ Go about your business
□ Go to the hospital

HOSPITAL

13. If taken to the hospital, how?
□ By ambulance □ Drove by yourself
□ Driven by friend
Name of hospital ____
Were you seen in the emergency room □ Yes
□ No
Were you admitted into the hospital □ Yes □ No

If admitted, how long did you stay? ____________________________

Name of admitting or hospital physician ________________________

In emergency room or hospital – What was done?

□ Examination □ Cervical collar
□ Complete bed rest □ X-Rays
□ Stitches □ Physiotherapy
□ Prescription □ Other

____

14. After your release – What did you do?
□ Return to work □ Return home to bed
□ Other ____________________

15. Did you consult another physician □ Yes □ No
Name of Doctor ____________________________________
Date of visit ______________________________________
What did he do for you?______________________________
Are you still seeing him □ Yes □ No

Past history

16. Have you been in any previous accidents?
____

17. Have you ever been treated for neck or back problems before?

____

18. Have you enjoyed good health prior to the accident? ____________________________________

19. Have you had previous surgery or conditions that I should know about?______________________
____

20. What are your present complaints?
____
____
____

21. Did you miss work as a result of this accident? □ Yes □ No
If yes, what dates? ____

22. Do you have an attorney representing you? □ Yes □ No
If yes, please write your attorney's information below:
Name____
Address ______________________________________
____
Phone#_______________________________________

23. Since the accident, have you been Unable to:

□ Return to work □ Exercise □ Resume daily activities
□ Drive □ Sleep
□ Other ______________________

Since the accident are you:
□ Bedridden
□ Walking with a limp
□ Having psychological side effects
□ Having anxiety while driving
□ In need of live-in help or care for yourself
□ In need of assistance of a walker, wheelchair, cane or crutches
□ Able to return to work
□ Able to return to work on light duty only Restrictions
□ No bending
□ No lifting
□ No twisting

24. Additional comments
____
____
____
____
____

Jason A. Bailey, D.C.

224 South park Circle East, St. Augustine, FL 32086, Tel: 904-342-4941