Sunshine Medical Centers
RESTORE... REVIVE... REGENERATE...

DATE: _____ CHART: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email: _____ Referred By: _____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse DOB: _____ Spouse SSN: _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

Patient Complaints: _____

_____

_____

Date Symptoms Began _____

How Problem Began _____

Is this ☐ Work Related ☐ Auto Related ☐ Unknown

Current Complaint (How You Feel Today)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)

0 1 2 3 4 5 6 7 8 9 10
No interference Unable to carry on activities

SSS=Stabbing

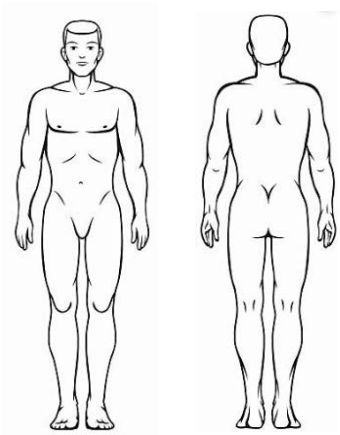
PPP=Pins & Needles

AAA=Aching

BBB=Burning

NNN=Numbness

Place symbol on pain area



How often are your symptoms present? (0-25% 26-50% 51-75% 76-100%) (Day or Week)

What makes your condition better? ☐ Exercise ☐ Heat ☐ Ice ☐ Lying Down ☐ Medications ☐ Rest ☐ Sitting ☐ Standing ☐ Stretching

What makes your condition worse? ☐ Bending ☐ Coughing ☐ Lifting ☐ Sitting ☐ Sneezing ☐ Standing ☐ Walking

Please check all of the following that apply to you:

- ☐ Recent fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke Date: _____
- ☐ Use Cortisone/Prednisone
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor _____
- _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Pregnant; # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Epilepsy/Seizures

Other Health Problems: _____

Please check all that apply to your family member:

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Stroke

DATE: _____ CHART: _____

Weight: _____ Height: _____ BP: _____

List all Surgeries and Dates: _____

_____

Current Medications: _____

_____

Current Nutritional Supplements: _____

_____

Allergies: _____

_____

Have you ever seen a chiropractor before? ◯ YES ◯ NO If Yes, Who and When? _____

_____

Family Physician: _____ Date Last Seen: _____

Smoking:	◯ Never	◯ <1 pack/day	◯ <1-2 packs/day	◯ Over 2 packs/day
Caffeinated Drinks:	◯ Never	◯ 1 glass/day	◯ 2-3 glasses/day	◯ More than 3 glasses/day
Alcohol Consumption:	◯ Never	◯ 1 glass/day	◯ 2-3 glasses/day	◯ More than 3 glasses/day
Exercise:	◯ Never	◯ 1 day/week	◯ 2-3 days/week	◯ More than 4 days/week

Kinds of exercise: _____

The undersigned agrees to and understands all information of this agreement. I accept financial responsibility for services given regardless of insurance reimbursement to provider. Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with a Sunshine Medical Center's employee. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

I hereby consent to the performance of examination and treatment on me by the licensed doctors of chiropractic, certified therapy assistants and any other technical support staff who may be employed or engaged in practice in this clinic. I understand that while very small, there are certain degrees of risk associated with chiropractic care and with any all supportive physical therapeutic modalities. These risks include, but are not limited to fracture, disc injury, stroke, sprains, strains, and soreness. I am therefore willing to accept and consent to the risks associated with the care I am about to receive.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

We do not identify, diagnose, or treat any disease. We help enable the body to optimize its ability to recover and maintain homeostasis. Although we have a high success rate, results may vary.

_____ _____

Signature ◯ Patient ◯ Guardian Date