

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits,  
if any, otherwise payable to me for services rendered. I understand that I am  
financially responsible for all charges whether or not paid by insurance. I  
authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose  
such information to the above-named Insurance Company(ies) and their agents  
for the purpose of obtaining payment for services and determining insurance  
benefits or the benefits payable for related services. This consent will end when  
my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date \_\_\_\_\_

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

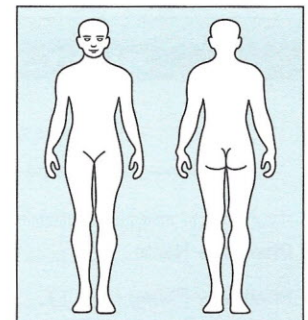
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting  
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down





## HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	

### EXERCISE

☐ None  
☐ Moderate  
☐ Daily  
☐ Heavy

### WORK ACTIVITY

☐ Sitting  
☐ Standing  
☐ Light Labor  
☐ Heavy Labor

### HABITS

☐ Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_  
☐ Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_  
☐ Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_  
☐ High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant? ☐ Yes ☐ No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

# **ARMSTRONG CHIROPRACTIC FAMILY CENTER, INC.**

*Florida Chiropractic Association*

*"Chiropractor of the Year", 2000*

*"National Humanitarian of the Year" 2015*

*Patrick AFB 45<sup>th</sup> Space Wing, 920<sup>th</sup> Air Rescue Wing*

*American Red Cross Volunteer DC since 2012*

*Palmer College of Chiropractic Adjunct Professor*



*1401 North Atlantic Avenue*

*Cocoa Beach, FL 32931*

*(321) 783-4455*

*Brevard County Sheriff's Office*

*SWAT Team Volunteer DC since 1998*

*Brevard County Stand Down DC since 2003*

*"That's one small adjustment to your spine...one giant leap for your health!"*

## **Electronic Health Records Intake Form**

In compliance with the Affordable Care act

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Email address** \_\_\_\_\_ **@** \_\_\_\_\_

**Preferred method of communication for patient reminders:** Email/ Mail/ Phone/ Text Cell Carrier: \_\_\_\_\_

**DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Gender (Circle one):** Male / Female **Preferred Language:** \_\_\_\_\_

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasion) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications? Updates to your medications?** (Please list regularly used over the counter medications)

Medication Name	Dosage & Frequency

**Do you have medication allergies?**

Medication Name	Reaction	Onset Date	Additional Comments

**I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care).

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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## **CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT**

I hereby authorize Dr. Armstrong and whomever he may designate as assistants to administer chiropractic treatment and exams.

## **REQUEST FOR RELEASE OF RECORDS**

I hereby request and authorize you, your employees, and/or agents to furnish to Dr. Orland K. "Lance" Armstrong, Armstrong Chiropractic and/or anyone designated in writing by Dr. Armstrong, all records and reports, including X-rays and photo static copies, abstracts, and/or excerpts of all records and any other information he/she/they may request relating to any examination, treatment, and/or opinion(s) concerning any condition that I may have had in the past, now have, or may have in the future.

## **RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT**

I have been offered to read a copy of Armstrong Chiropractic's Notice of Privacy Practices.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(if a Minor Patient, Name of Guardian)

\_\_\_\_\_  
(Witness)