

**WELLNESS CONCEPTS OF FLORIDA
CONFIDENTIAL PATIENT HISTORY**

Date _____

Name _____ M F Home Phone (____) _____
Other Phone (____) _____

Address _____ City _____ ST _____ Zip _____

Age _____ Birth Date _____ Social Security # _____

Marital Status M S W D No. of Children _____ Email _____

Occupation _____ Employer _____

Address _____

Work Phone(____) _____

Name of Spouse _____ Spouse Social Security # _____

Spouse Employer _____ Work Phone (____) _____

Address _____

Name of Emergency Contact _____ Phone (____) _____

How do you prefer to be verbally addressed? _____

Whom may we thank for referring you? _____

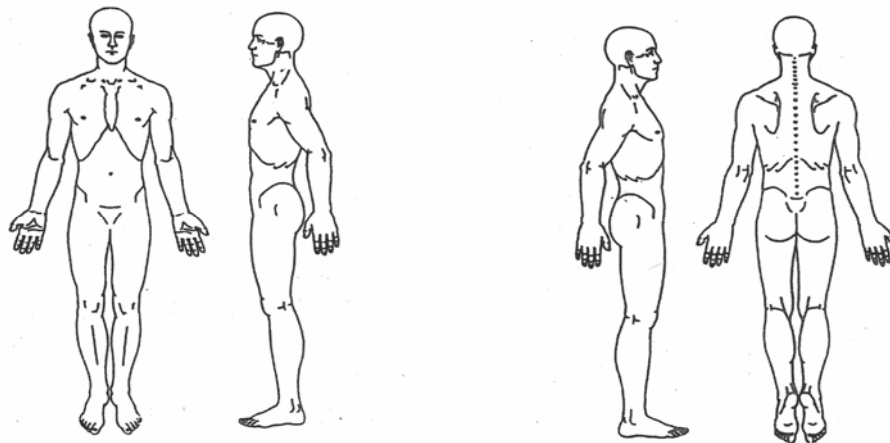
FAMILY DOCTOR/PRIMARY CARE PHYSICIAN _____

May we contact your physician regarding your care at this office? Yes No

(Some managed care plans may require contact between our office and the referring physician)

Present Complaint(s): _____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDING NUMBNESS, TINGLING, ANY CHANGE IN SENSATION OF FEELING, ETC.



When did your problems begin? Specific date if possible _____

How did your problem begin? _____

Is there any dizziness associated with your symptoms? Yes No

Have you had anything similar to this in the past?? Yes No If yes, please explain _____

For your present complaint, have you seen any other doctors? Yes No If yes, who? _____

What treatment? _____

How intense is your pain? Minimal Mild Moderate Severe/Excruciating

Please describe the character of your current pain. (check all that apply).

Sharp/Stabbing Burning Radiating Aches Sore Weakness Throbbing
 Numbness Tingling Dull Pressure Other _____

How often are the complaints present? Constant/100% of time Frequent/75% Intermittent/50%
 Occasional/25% Comment: _____

Is the pain: Increasing Decreasing Not Changing?

Pain is aggravated by: Walking Sitting Standing Riding in a car Lifting
 Bending Stretching Twisting Other _____

Pain is reduced by: Medicine, Exercise, Rest, Adjustment, Massage, Therapy, etc _____

What would you like to do, but can't because of your pain/condition? _____

Are your complaints affecting your ability to work or be active?

No effect Some physical restrictions Unable to perform regular duties

Any fever or chills? Yes No _____

Are your complaints affecting your sleep? Yes No _____

Any change in bowel and bladder (bathroom) function? Yes No _____

Have you missed days of work or school? Yes No Dates missed: _____

Please list any allergies (Drug or Other). _____

Have you broken any bones? Yes No If yes, explain: _____

List any significant health history of parents and/or siblings (Diabetes, cancer, heart disease, etc) _____

Have you ever been hospitalized for any reason? Yes No Please explain _____

Have you ever been in any accident(s) (sports included)? Yes No Please list date of each: _____

What **Non-prescription** meds are you taking? ___ Tylenol ___ Ibuprofen/Advil ___ Aspirin ___ Other _____

What **Prescription** Meds are you taking?

Anti-Inflammatory Pain Killers Muscle Relaxers Blood Pressure Insulin
 Birth Control Tranquilizers Diet Pill Other _____

Do you smoke? Yes No How much? _____

Consume alcohol? Yes No How much? _____

What is your exercise routine? _____

Other health concerns: _____

GOALS (Please circle all that apply)

Pain Relief Only

Nutrition

Rehab/Exercise

Wellness Plan

QUESTIONS _____

Patient Signature

Date