



Chiropractic Office of Dr. Jeffrey S. Gordon
305 S.W 7th. Terrace, Gainesville, Fl 32601 • (352)336-6767

CONFIDENTIAL PATIENT INFORMATION

**Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
THANK YOU.**

Date _____ **Patient #** _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ Number of Children _____ Spouse's Name _____

Occupation _____ Email Address _____

Cellular Telephone (Optional) _____ Emergency Contact _____

HEALTH INFORMATION: Have you had previous chiropractic care _____

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes and goes _____

Is this condition interfering with your: Work _____ Sleep _____ Daily routine _____ Other _____

List surgical operations and years: _____

Date of Last Physical Examination: _____ Weight: _____ Height: _____ R/L Handed

You are currently suffering from:

- Recurring headaches
- Eye or sinus pain
- Facial spasms
- Restricted movement head/neck
- Neck pain
- Neck spasms
- Poor posture
- Upper back pain
- Painful/stiff joints
- Restricted movement shoulder/arm/hand
- Pain around shoulder blade
- Pain around collar bone
- Mid back pain
- Chest pain
- Rib cage pain
- Pain around breast bone
- Scoliosis
- Low back pain
- Buttock pain
- Hip pain
- Restricted movement leg/foot
- Leg pain-lower/upper
- Sore/weak muscles
- Walking problems

Insurance Information:

Is your condition due to an auto accident or job related injury? Yes _____ No _____

Do you have health insurance? Yes _____ No _____

If yes, Name of Company _____ Policy # _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient's Signature _____ **Date** _____

Guardian or Spouse's Signature _____ **SS #** _____

Review of Systems

Name _____ Date _____ File # _____

Please answer carefully the following, as this information can affect your overall course of chiropractic care

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

Gastro-Intestinal

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

Musculoskeletal

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing
- Clicking Jaw
- General Stiffness

FEMALES ONLY

What was the first day of your last period? _____
Are you pregnant?
 Yes No Not Sure

Male/Female

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat

Genito-Urinary

- Bladder Trouble
- Painful/Excess Urination
- Discolored Urine

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulties
- Stuffed Nose

Heart Problems

- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Office Use Only:

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