



Chiropractic Office of Dr. Jeffrey S. Gordon  
305 S.W 7<sup>th</sup>. 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       | <b>INTAKE</b>                        |
| <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
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

#### General

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

#### Office Use Only:

## History of Occurrence

Date of accident \_\_\_\_\_ Time \_\_\_\_\_ AM PM

Driver of car \_\_\_\_\_ What seat were you sitting in? \_\_\_\_\_

Who owns the car? \_\_\_\_\_ Year and model of car \_\_\_\_\_

What was the approximate damage done to the car you were in? \$ \_\_\_\_\_

Visibility at time of accident: Poor Fair Good

Road conditions at time of accident: Icy Rainy Wet Clear Dark

Your car: Hit another car or Was hit in the: Right Left Rear Front Side

Type of accident: Head-on collision Broad-side collision Rear-end collision Front impact, rear-ended car in front

Other \_\_\_\_\_

## Impact/Seat Belt/Head Rest/Speed

Describe in your own words what happened to you upon impact: \_\_\_\_\_  
\_\_\_\_\_

Were you prewarned and braced for the impact? YES NO

Does your car have headrest? YES NO If yes, what was the position of headrest compared to your head at the time of the accident?

Top of headrest: even with middle of neck even with bottom of head even with top of head

Were seat belts worn? YES NO

Was your car braking? YES NO

Was your car moving at the time of the accident? YES NO

If yes, how fast would you estimate you were going? \_\_\_\_\_ MPH (estimate)

How fast would you estimate the other care was traveling? \_\_\_\_\_ MPH (estimate)

## Head/Body Position/Able To Move Body

Head/Body position at time of impact: Head turned right or left Head looking back Head straight forward

Body straight in sitting position Body rotated right or left

At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: \_\_\_\_\_  
\_\_\_\_\_

As a result of the accident you were: Rendered unconscious Dazed, circumstances vague Shaken up, but could function

Could you move all parts of your body? YES NO

If no, what body parts could you not move and why? \_\_\_\_\_  
\_\_\_\_\_

Were you able to get out of the car and walk unaided? YES NO

If no, why couldn't you get out of the car and walk unaided? \_\_\_\_\_

### Symptoms From Accident

Did you get any bleeding cuts or bruises? YES NO

If yes, what bleeding cuts did you receive from this accident? \_\_\_\_\_

If yes, what bruises did you receive from this accident? \_\_\_\_\_

Please describe how you felt immediately following the accident. Please be specific. \_\_\_\_\_

Later that day \_\_\_\_\_

Later that night \_\_\_\_\_

The next day (s) \_\_\_\_\_

### Work Status History

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Have you missed time from work? YES NO

If yes, how many full-time days? \_\_\_\_\_

If yes, how many part-time days? \_\_\_\_\_

Have been unable to work since the accident

### Hospitals/Clinics/Doctors Seen

Did you go to seek medical help immediately/soon after the accident? YES NO

If yes, how did you get there? Someone else drove me Drove myself Ambulance Police

First Doctor/Hospital/Clinic Seen \_\_\_\_\_ Date \_\_\_\_\_

Were you examined? YES NO X-rays taken? YES NO

Were you given treatment? YES NO If yes, what treatment was given? \_\_\_\_\_

What benefits did you receive from this visit? \_\_\_\_\_

Second Doctor/Clinic Seen \_\_\_\_\_

Were you examined? YES NO X-rays taken? YES NO

Were you given treatment? YES NO If yes, what treatment was given? \_\_\_\_\_

What benefits did you receive from this visit? \_\_\_\_\_

Third Doctor/Clinic Seen \_\_\_\_\_

Were you examined? YES NO X-rays taken? YES NO

Were you given treatment? YES NO If yes, what treatment was given? \_\_\_\_\_

What benefits did you receive from this visit? \_\_\_\_\_

### **Prior/Similar Symptoms**

Did you have any physical complaints just before the accident?    YES    NO

If yes, what physical symptoms did you have just before the accident? \_\_\_\_\_

Prior to this accident, have you ever had symptoms similar to what you're experiencing now?    YES    NO

If yes, please explain (briefly include past falls, surgeries, broken bones, serious illnesses, accidents, operations, etc.) \_\_\_\_\_

### **Attorney on Case**

Do you have an attorney on this case?    YES    NO

If yes, who?    Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_

How were you recommended to our office?

- Phone Book
- Internet
- Friend
- Attorney
- Other \_\_\_\_\_