**CHERY CHIROPRACTIC CENTER**
**CARINE CHERY, D.C.**
1900 CRYSTAL DRIVE, STE.1
FORT MYERS, FL 33907
TEL: (239) 936 6566 FAX: (239) 936 6442
Email: cherychiro@yahoo.com

**NAME: _____ DATE: _____**

**ADDRESS: _____ _____CITY:_____**

**STATE: _____ ZIP CODE: _____**

**HOME PHONE: _____CELL PHONE: _____**

**OCCUPATION: _____ COMPANY NAME: _____**

**EMAIL ADDRESS: _____**

**SEX: MALE: _____ FEMALE: _____ DATE OF BIRTH: ___/____/_____**

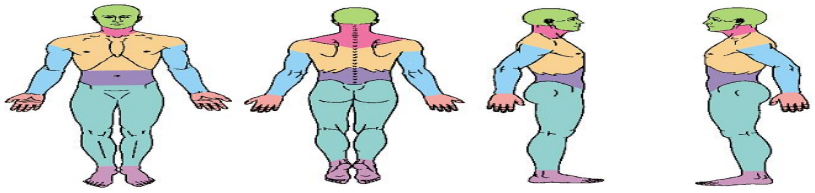
**SINGLE: _____ MARRIED: _____ SEPARATED: _____ DIVORCED: _____**

**HEIGHT: _____ WEIGHT: _____**

**SOCIAL SECURITY Last For Digits: _____**
**Who referred you to us? _____**
**How else did you hear about us? : _____**
**PRIMARY CARE MEDICAL DOCTOR: _____**
**PRIOR CHIROPRACTIC CARE: ( ) Yes ( ) No**
**CHECK YOUR PRESENT COMPLAINTS:**
**( ) Neck Pain/Stiffness/ Spasms: ( ) Right ( ) Left ( ) Both sides**
**( ) Upper back and Shoulders: ( ) Right ( ) Left ( ) Both sides**
**( ) Mid Back Pain/Stiffness/Spasms: ( ) Right ( ) Left ( )Both sides**
**( ) Low Back Pain/Stiffness/ Spasms: ( ) Right ( ) Left ( ) both sides**
**( ) Headaches: ( ) Back of head ( ) Top of Head ( ) Right side ( ) Left Side ( ) Front**
**( ) Arm/Hand/Finger Numbness/ Tingling: ( ) Right ( ) Left ( ) Both Sides**
**( ) Buttock/Leg/Foot/Toe Numbness/Tingling: ( ) Right ( ) Left ( ) Both Sides**
**( ) Knee/Hip Pain: ( ) Right ( ) Left ( ) both sides**
**( ) Arm/Shoulder Pain: ( ) Right ( ) Left ( ) both sides**
**( ) Other Complaints:_____**
**DATE YOUR SYMPTOMS STARTED: _____**

**Mark on the picture where you hurt: How bad is your pain? On a scale of 1 to 10**

**<----------------------------------------------------->**
**1(no pain) 2 3 4 5 6 7 8 9 10 (severe)**



**Front back right left**

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

**Do any positions make it feel worse? _____**

**CHERY CHIROPRACTIC CENTER**

**Do any positions make it feel better? _____**

**Is this condition: ( ) Improved ( ) Unchanged ( ) Getting Worse**

**Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine Other_____**

**WHAT CAUSED YOUR PRESENT COMPLAINTS?**

**( ) Unknown ( ) Auto Accident ( ) Work Injury ( ) Personal injury ( ) Other**

**EXPLAIN:_____**

**PAST ACCIDENTS/INJURIES: ( ) YES ( ) NO _____**

**( ) Auto Accidents: Date: _____( ) Work Injuries: Date: _____**

**DO YOU HAVE A PERMANENT INJURY/DISABILITY? ( ) YES ( ) NO _____**

**What is your impairment/disability rating? _____**

**MEDICATIONS:**

1. **List regular medications that you take:_____**
   **_____**
2. **List regular over the counter medications that you take:_____**
   **_____**

**DIET AND EXERCISE:**

1. **Do you smoke? ( ) Never ( ) Former Smoker ( ) Current/Every Day Smoker**
2. **Do you exercise regularly? # of times weekly: 0 - 1- 2- 3- 4- 5- 6- 7**

**ALLERGIES:**

1. **Any allergies? ( ) No ( ) If yes List them _____**

**HEALTH HISTORY:**

1. **Have you been hospitalized in the last 5 years? ( ) No ( ) Yes date Hospitalized: _____**
2. **Have you been diagnosed with Diabetes? ( ) No ( ) Yes ( ) Type I ( ) Type II**
3. **Have you been treated for hypertension? ( ) Yes ( ) No**

**CANCER:**

1. **Has a physician ever diagnosed you with cancer? ( ) Yes ( ) No _____**

**CARDIOPULMONARY AND CIRCULATORY HEALTH:**

1. **Ever been diagnosed you with any heart, lung, or circulation disorder? ( ) Yes No ( )**

**EMOTIONAL AND MENTAL HEALTH:**

1. **Ever been diagnosed you with any emotional or mental health disorder? ( )Yes ( ) No _____**

**SENSORY HEALTH:**

1. **Ever been diagnosed you with any sensory disorder? ( )Yes ( ) No ? _____**

**MUSCULOSKELETAL HEALTH:**

1. **Ever been diagnosed you with any muscular or spinal disorder? ( ) Yes ( ) No _____**

**REPRODUCTIVE HEALTH:**

1. **Ever been diagnosed you with any reproductive disorder/ dysfunction? ( )Yes ( )No**

**FEES ARE PAYABLE AT THE TIME SERVICES ARE PERFORMED UNLESS OTHER ARRAGEMENTS ARE**

**HOW WILL PAYMENT BE MADE: ( ) Cash ( ) Check ( ) Credit Card**

**( ) Health Insurance ( ) Auto Insurance ( ) Work Comp.**

**NAME OF INSURANCE COMPANY: _____**

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# INFORMED CONSENT TO CHIROPRACTIC CARE

**Patient: Please discuss any questions or concerns with Doctor before signing this consent.**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Through chiropractic adjustments and treatments that are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that I will be receiving the following treatment:

- Chiropractic Adjustment
- Electrical Muscle Stimulation
- Therapeutic Exercises
- Manual Therapy
- Extremity Manipulation
- Ultrasound
- Hot Pack/Cold Pack
- Mechanical Traction

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized, I have had the opportunity to read this form and this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Patient/Guardian _____ Date _____

(If patient is a minor)

## Assignment & Release

**Insurance Information**

**I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and m yself. Furthermore, I understand that this 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 doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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, any fees or outstanding balances for services I have received will be immediately due and payable.**

**Patient's/Parent's/Guardian's Signature_____**

**Consent of Professional Services and Release of Information**

**I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.**

**Patient's/Parent's/Guardian's Signature_____**