Bennett Chiropractic Clinic, Inc. **Carl H. Bennett, D.C.**
3945 South Nova Road **Phone: 386-767-1100**
Port Orange, FL 32127 **Fax: 386-767-1103**

PATIENT INFORMATION

Full Name _____ Birth Date _____ Gender: M / F
Address _____ City _____ St ____ Zip _____
Home Phone: _____Work Phone: _____
Cell Phone: _____ Email Address: _____
Marital Status: S M W D Sep SS# ____-___-____ Spouse Name _____
Emergency Contact: Name _____ Relationship _____ Phone _____

Are you a student? Yes No / Full-time Part-time

Your Employer _____Your occupation _____
Employer Address _____ City _____ St _____ Zip _____
Spouse's Employer _____Spouse's occupation _____

INSURANCE **(please allow our staff to photocopy your insurance information and driver's license)**
This is necessary for audit and billing purposes.

How did you hear about our office? _____
Did someone refer you? _____ Who? _____

- I authorize payment of medical benefits to this office
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manger.
- If your account is turned over to a collection agency for non-payment, you will be responsible for any cost incurred in collections of said balance. This could include collection agency fees of up to 35% of your outstanding balance, court costs and attorney fees.

Patient Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

(Authorization expires 3 years from date above.)

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CASE HISTORY

FULL NAME: _____ DOB: _____ FILE #_____

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also, the length of time you have had these complaint(s).

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

Is your condition(s) related to an accident? □ YES □ NO
Date of accident: _____
Type of accident: □ Auto □ Work related □ Other _____

What words best describe your present condition(s)? (ex. ache, burn, tingling, etc) _____

Circle the number that matches your level of pain at its worst
(0 = no pain, 10 = most severe) 0 1 2 3 4 5 6 7 8 9 10

How intense is the problem? □ Mild □ Moderate □ Severe

When does the problem occur? (ex. standing, sitting, exercise, etc.) _____
When is your condition most severe? _____
When is your condition least severe? _____

Is your condition: □ Getting worse □ Staying the same □ Getting better □ Comes & goes
□ Other (explain) _____

Have you ever had the same or similar condition(s) in the past? □ YES □ NO
If yes, please explain _____

What makes your condition feel worse? _____
What makes your condition feel better? _____
What activities are difficult because of your condition(s)? _____

Have you seen any other health care providers for your present condition? □ YES □ NO
If so, who? _____

Current medications or vitamins _____

Do you have a pacemaker? □ YES □ NO
Are you or could you be pregnant? □ YES □ NO

Are you experiencing or do you have any of the following?

Check symptoms you have noticed.
Use **N** if it's a problem **NOW**, use **P** if it's a problem from the **PAST**, leave blank if it doesn't apply.

□ A sore that won't heal	□ Difficulty swallowing	□ Persistent cough/hoarseness
□ Any bleeding/discharge	□ Lump/thickening anywhere	□ Wart/mole changes
□ Bladder/bowel problems	□ Night pain	□ Weight loss without trying
□ Headaches	□ Head feels heavy	□ Light headed
□ Loss of balance	□ Dizzy	□ Nervous
□ Fatigue	□ Loss of hearing	□ Blurred vision
□ Chest pain	□ Pain in shoulder	□ Muscle spasm in shoulder
□ Pain in neck	□ Stiff neck	□ Muscle spasms in neck
□ Pain in arm and hand	□ Pins and needles in arms/hands	□ Loss of grip strength
□ Mid back pain	□ Pain between shoulders	□ Low back pain
□ Low back muscle spasm	□ Pain into buttock	□ Pain into thigh
□ Pain down leg	□ Pain in ankle	□ Pain in foot
□ Pain in knee	□ None of the above	□ Other _____

Review of Systems

Height: _____ Weight: _____

Do you have any heart, lung, bowel or urinary problems? □ YES □ NO
If yes, please explain _____

Is there anything else about your health of past medical history that you believe we should know about?
□ YES □ NO If yes, please explain _____

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Have you ever been hospitalized for anything in addition to surgeries? □ YES □ NO
If yes, when and for what reason _____

Have you ever been diagnosed as having a particular condition? (diabetes, heart trouble, cancer) □ YES □ NO
If yes, please explain _____

Are you currently under a doctor's care for any condition(s) other than the ones you are seeking care for in this office? □ YES □ NO If yes, please explain _____

Patient Signature _____ Date _____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Carl H. Bennett and whomever he may designate as his assistants to administer treatment(s) as he so deems necessary. Dated in Port Orange, FL, on this _____ day of _____, 20____.

Signed _____, relationship to patient _____

Witnessed _____

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