MEANS FAMILY CHIROPRACTIC

150 PONDELLA ROAD
NORTH FT. MYERS, FL 33903

"Our purpose is to educate and adjust as many families as possible towards optimal health through *Specific Chiropractic Care*"

Patient's Name: ______________________________ Date: ____________

Reason For Seeing Doctor Today: ______________________________
Are your present injuries due to an automobile accident or an on the job injury? ☐ Yes ☐ No
If yes, what was the date of the accident? ____________ Present M.D. ____________

Please (✓) any existing symptoms (body signals) you are experiencing!

GENERAL SYMPTOMS
___ Headaches
___ Fever
___ Fainting
___ Dizziness
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or Pain in Arms/Hands
___ Numbness or Pain in Legs/Feet

GASTRO-INTESTINAL
___ Nausea
___ Vomiting Blood
___ Stomach Problems
___ Constipation
___ Diarrhea
___ Colon Trouble

EYE EAR NOSE THROAT
___ Pain In Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Nose Bleeds
___ Sore Throat
___ Frequent Colds
___ Sinus Trouble

RESPIRATORY
___ Chronic Cough
___ Spitting Blood
___ Chest Pain
___ Diff. Breathing
___ Asthma
___ Allergies

CARDIO-VASCULAR
___ High Blood Pressure
___ Low Blood Pressure
___ Swelling of Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes Date ________

MUSCLE & JOINT
___ Pain in Neck
___ Pain in Mid-Back
___ Pain in Low-Back
___ Weakness
___ Twitching
___ Swollen Joints
___ Foot Trouble
___ Pain Between Shoulders
___ Spinal Curvature

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infections
___ Bed Wetting
___ Prostate Trouble

FEMALES ONLY
___ Painful Periods
___ Irregular Cycles
___ Hot Flashes
☐ Yes ☐ No Pregnant
If no, sign below

By my signature on this form, I ____________
do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.
PATIENT'S SIGNATURE ____________
WITNESS'S SIGNATURE ____________

Please list any present or past diseases. ______________________________

Please list any past surgeries. ______________________________

Please list any past accidents (Automobile, work, sports, slips or falls). ______________________________

Please list any broken bones or dislocations. ______________________________

Do you suffer from any condition other than that which you are consulting us? ☐ Yes ☐ No
If yes, what condition? ______________________________

Please list all medications that you are presently taking. (prescription/non-prescription) ______________________________

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The patient agrees he/she is responsible for payment for all bills incurred at this office. To avoid added bookkeeping expenses, payment is expected at the time service is rendered unless other arrangements are made.

Signature: ______________________ Date: ______________________