MEANS FAMILY CHIROPRACTIC

File No. _____

PATIENT INTRODUCTION CARD

NAME _____ DATE _____ MARITAL STATUS:

ADDRESS _____ PHONE _____ Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ HT. _____ WT. _____

CELL PHONE _____ EMAIL ADDRESS _____

No. in immediate family presently being treated in this office _____ NO. OF CHILDREN _____

Occupation _____ Social Security Number _____

Employed by _____ Business Phone _____

Name of Spouse _____ Employed by _____

Business Phone _____

In Case of Emergency: _____ Have you received chiropractic care before? _____

If so, where? _____

DO YOU HAVE HEALTH INSURANCE? _____ WHAT COMPANY? _____

Charges for todays services will be paid by ____ Cash ____ Check ____ Visa ____ Mastercard ____ Other

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

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. _____

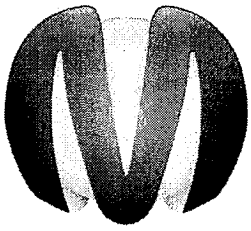
Do you suffer from any condition other than that which you are consulting us? ☐ Yes ☐ No
If yes, what condition? _____

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

_____

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: _____



MEANS FAMILY CHIROPRACTIC

Mark C. Means, D.C., P.A.
Rick A. Means, D.C., P.A.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders, birthday greetings or promotions by:

_____ Mail

_____ Email --- at email address _____

_____ Telephone --- at phone number(s) _____

_____ Voice Mail

_____ Text Message

_____ I authorize the doctor to personally discuss with me products that may benefit my health or condition.

List below the names and relationship of people to whom you authorize the Practice to release Personal Health Information.

_____ _____

_____ _____

_____ _____

_____ _____
Print Name **Date**

_____
Signature