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: ______________________