Dr. Robert DeVincentis
Intracoastal Chiropractic Clinic
14255 Beach Blvd, Suite A * Jacksonville FL 32250

Patient History Form

Last Name:_____ First:_____ Middle:____ ☐Single ☐Married ☐Divorced
Date:___/___/_____ Date of Birth:___/___/_____ Social Security #:_____
Address:_____ Apt#:_____ Email:_____
City:_____ State:_____ Zip:_____-_____
Employer:_____ Work Phone:_____Ext.:_____
Home Phone:_____ Cell Phone:_____
Emergency Contact Name:_____ Phone:_____ Relationship:_____
Who Referred You To This Office?_____

Who is Responsible for Your Bill?
☐Health Insurance ☐Auto Insurance ☐Cash ☐Medicare ☐Medicaid ☐Work Comp. ☐Other

Are you here as a result of an accident? ☐No ☐Yes If Yes, Date of Accident:___/___/_____
Have you ever been to a Chiropractic Physician Before? ☐No ☐Yes If Yes, Date of last visit ___/___/_____
If Female, is it possible you are pregnant? ☐No ☐Yes If yes, # of weeks?____ First Child? ☐No ☐Yes

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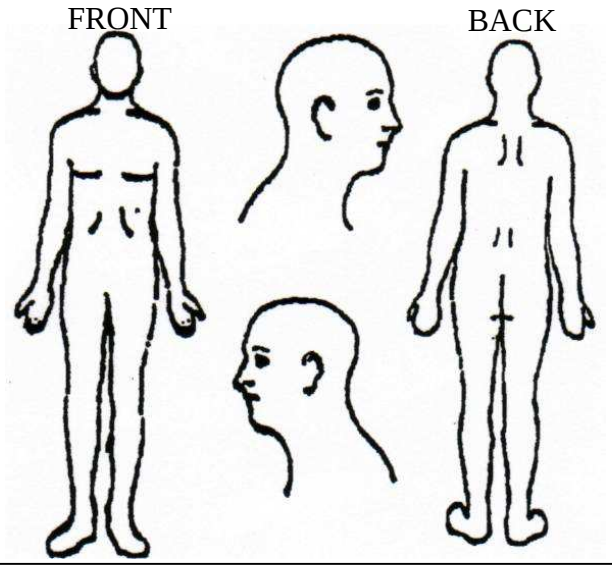
What Symptoms brought you here today? _____
_____
_____
_____

Place an appropriate letter that describes the pain on the drawing in the area shown. If letter does not apply, mark "X"

A=Ache
B=Burning
S=Stabbing
N=Numbness
P=Pins & Needles



PAIN SCALE
Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Describe your past Health History

Prior Illness: _____
_____
Past Hospitalizations: _____
_____
Surgeries: _____
_____
Medications: _____
_____
_____

**** Continued on Back****

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Check any of the symptoms you have been experiencing:

☐Neck Pain	☐Upper Back Pain	☐Middle Back Pain	☐Lower Back Pain
☐Headache	☐Nausea	☐Chest Pain	☐Dizziness
☐Loss of Balance	☐Ring in Ears	☐Numbness in Arm/Hand	☐Numbness in Leg/Foot
☐Pain in Arm/Hand	☐Pain in Leg/Foot	☐Sensitivity to Light	☐Neck Stiffness
☐Cold Sweats	☐Head Feels too Heavy	☐Memory Loss	☐Upset Stomach
☐Loss of Taste	☐Loss of Smell	☐Shortness of Breath	☐Sleeping Problems

When did the condition begin?_____ How did this condition develop?_____
_____
Ever had this problem before? ☐No ☐Yes If yes, explain: _____
Ever receive treatment for this condition? ☐No ☐Yes If yes, when, where and what were the results?
_____
Has this problem been getting: ☐Better? ☐Worse? ☐Staying the same?
What makes your condition better? _____
What makes your condition worse? _____
Does anyone in your family have a back or neck problems? ☐No ☐Yes If yes, who? _____
Do you have or have you had: ☐High Blood Pressure ☐Cancer ☐Diabetes
☐Kidney Problems ☐Heart Problems ☐Other:_____
Does or did any immediate family member have: ☐High Blood Pressure ☐Cancer ☐Diabetes
☐Kidney Problems ☐Heart Problems ☐Other:_____

Do you use tobacco? ☐No ☐Yes If yes, type and amount per day _____
Do you suffer from alcohol or drug abuse? ☐No ☐Yes If yes, explain _____
Do you suffer from allergies? ☐No ☐Yes If yes, to what? _____

If your condition is Due To An Auto Accident - Please complete the following:(If not then Disregard)
In the accident, were you the ☐Driver? ☐Passenger? ☐Pedestrian?
Were you aware of the upcoming collision? ☐No ☐Yes
Were you wearing a seatbelt? ☐No ☐Yes
Were there airbags in the car? ☐No ☐Yes If yes, did they go off? ☐No ☐Yes
Did you go to the hospital? ☐No ☐Yes If yes, what hospital? _____
Did you go to any other doctors? ☐No ☐Yes If yes, who? _____
Explain in detail how the accident occurred. Use a diagram if needed. _____
_____
_____
_____
_____
_____

Patient's Signature:_____Date:_____

Doctor's Signature:_____