Intracoastal Chiropractic Clinic

14255 Beach Blvd. Ste 300

Jacksonville, FL 32250

Medical Consultation/Treatment Record

Patient Name:	Tel Home:
Address:	Tel Work:
	Tel Cell:
	E-mail Address:
Date of Birth:	Gender (male/female):

How did you hear about us?:

Are you currently suffering or have you EVER suffered from any of the following:			
	Yes	No	Comment
Epilepsy			
Urine infection			
Diabetes			
Cancer			
HRT(hormone replacement therapy)			
Contraceptive			
Any Kidney problems or issues			
Auto immune disease			
Currently pregnant			
Gastric ulcers			
Any form of infection, fever or disease			
Cardio vascular condtions			
Regular antibiotics/medications taken			
Any condition already being treated by a practitioner:			
Use of recreational drugs or alcohol:			

LIST ALL medication / regular supplements that you are currently taking:

Do you have any of the following:			
	Yes	No	Comment
Thyroid problems			
Any metal pins/plates/cosmetic implants			
Dermatitis or other skin issues			
Muscular/skeletal problems			Back aches / Pain / Stiff joints / Headaches
Digestive problems			Constipation / Bloating / Liver / Gall bladder / Stomach
Gynecological problems			Irregular periods / PMT / Menopause
Nervous system			Migraine / Tension / Stress / Depression
Immune system			Prone to infection / Sore throats / Colds / Chest / Sinuses

Lifestyle Questions:			
	Yes	No	Comment
Last period dates:			
Job description:			
Do you eat regular meals?			How many per day?
Do you eat in a hurry?			
Do you exercise?			Please circle: Occasionally Irregularly Regularly
Please list all types of exercise:			
Do you take vitamin supplements?			If yes please list…
Do you suffer from allergies?			If yes please list…
How would you mark your current stress level? (1-10, where 1 is low, 10 is high)			
Do you smoke?			If yes, how many per day?
Do you drink alcohol?			If yes, approximate drinks per week?
Date of last visit to the doctor:			

Please list any recent operations/ fractures/ scars/ localized swelling: (within 3 months for fractures and 1 year for operations)

i-lipo

Why are you here today?_____

_____

Why did you choose i-Lipo?_____

What are 3 reasons you want to lose weight?_____

_____

_____

What's your motivation for losing weight? _____

_____

Do you have an important event (Wedding/ vacation/ graduation) coming up?_____

_____

What have you tried in the past that has worked to lose weight?_____

_____

What have you tried in the past that hasn't worked to lose weight?_____

_____

Why have you decided that now is a good time to get started? Why today?_____

_____

_____