Edelson Wellness Center

Steven Edelson, D.C., MSW
Chiropractic Physician
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4250 Bay to Bay Blvd. Tampa, Florida 33629

Date:_____

Mr. Mrs. Ms. Dr.
Name:_____ SEX : M F (circle one)
First Middle Init. Last
Nickname:_____ Email: _____ Age:_____
Address:_____
City:_____ State:_____ Zip: _____
SS Number: _____ - ____ - _____ Date of birth: (MM/DD/YEAR) _____
Home Phone:_____ Cell Phone_____ Work Phone:_____
How do you want to receive future appointment reminders?
email or text
Cell phone service provider? _____
Driver's License #: _____ State:___
Employer:_____ Occupation:_____
Name of spouse/significant other:_____
Who referred you to our office?_____
What is your major complaint?:_____
_____

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Is condition due to: A. work injury B. auto accident C. household accident
If condition was a result of any of above, what was the date of the accident**?** _____
If condition *WAS NOT* related to an *AUTO* accident, please describe what happened**:**
_____

PAYMENT INFORMATION: I do not have insurance _____
Your insurance company:_____
Insurance address:_____
_____
Insurance phone: (_____) _____ - _____ Name of insured: _____
Insured Date of Birth: _____ ID#:_____
Do you have an attorney representing you? YES NO
Name of attorney:_____ Phone Number: (____) _____ -_____

Fees are payable at the time of service, unless other arrangements have been made. Florida law requires that patient records including x-rays, be retained by the physician, but may be copied or released upon your request.

I authorize the above named doctor or clinic to furnish information concerning my present illness or injury and direct the insurer to pay, without equivocation, directly to the above named doctor or clinic, any and all benefits due them as a result of this claim. I am aware that I am personally responsible for all charges and/or balances not covered by my insurance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Patient's signature:_____ Date:_____
(I give my consent to treat)
Guardian/spouse's signature:_____ Date:_____
(I give my consent to treat)

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE

Describe your areas of complaint(s): List everywhere you hurt or have symptoms in order of importance. (The doctor will also make additions.)

_____

_____

_____

What caused your most recent symptoms?

_____

When did your present symptoms begin?

_____

Is this condition getting: Better _____ Worse _____ Staying the same _____ Other

_____

When are your symptoms worse? Morning _____ Afternoon _____ Evening _____ Night _____ Other

_____

What movements or positions aggravate your condition?

_____

What relieves your symptoms?

_____

Have you been treated for this recent condition? Yes _____ Date _____ No ____ Name of Dr._____

What was done?

_____

Describe your work:_____

How has this problem(s) affected you and your life?_____

Have you missed any work? _____ If yes, when?_____

Have you ever had a similar condition before? Yes _____ Date_____ No _____

Explain_____

_____

List all previous injuries or accidental falls and date(s) (including back pain)_____

List all previous operations and date(s)_____

List major illness (es) and date (s)_____

List present medications (prescription and non-prescription)_____

List all nutritional supplements_____

List any athletic activity or exercise_____

Previous Chiropractic care? Yes ____ Date _____ No ____ If yes Dr.?_____

CHECK THE FOLLOWING WHICH YOU HAVE HAD AND UNDERLINE ANY YOU HAVE NOW

GASTRO-INTESTINAL
Constipation
Diarrhea
Digestive Problems
Stomach Pain
Gall Bladder Trouble
Hemorrhoids
Liver Trouble
Hernia
Vomit of Blood

SKIN
Boils
Bruising
Dryness

GENITO-URINARY
Frequent Urination
Painful Urination
Difficulty Start Urine
Inability to Control Urine
Blood in Urine
Bed Wetting
Kidney Infection
Prostate Trouble

CARIO VASCULAR
High Blood Pressure
Spiting of Blood
Chest Pains
Low Blood Pressure
Previous Heart Trouble
Previous Stroke

RESPIRATORY
Chronic Cough
Difficulty Breathing
Nose Bleeds
Sinus Trouble
Asthma

EYES-EARS-NOSE
Earaches
Ear Discharge
Hard to Swallow
Nasal Discharge
Eye Pains

MUSCLES-JOINTS
Swollen Joints

GENERAL
Frequent Colds
Ringing in Ears
Cramps-Backache
Allergies
Weight Loss
Nervousness
Hoarseness
Foot Problems
Emotional Problems

WOMEN ONLY
Excessive Flow
Hot Flashes
Irregular Cycles
Painful Intercourse
Painful Menstruation

Date of Last: Spinal Examination_____ Spinal X-ray_____ Blood Test_____ Urine Test_____
Physical Exam_____ Chest X-ray_____ Have you ever tested positive for HIV/AIDS?_____
Signature _____ Print Name_____ Date_____