CoreHealth of Clearwater LLC
1501 S. Missouri Ave.
Clearwater, FL 33756
727-216-3216

Patient Name: ______________________________
Date of Birth: ________________

Medical History:

Have you been to a Chiropractor? Y or N

If yes: Name: ________________________ City/State: ____________________

Phone: ________________________

Do you have a Family Physician: Y or N

If yes: Date of Last Physical Exam: ______________

Have you been Hospitalized in the past 5 years? Y or N

If yes please describe: ____

Have you had Surgery in the past 5 years? Y or N

If yes please describe: ____

Have you had a serious Accident/Injury in the past 5 years? Y or N

If yes please describe: ____

Do you have any Allergies? Y or N

If yes please describe: ____

Are you currently taking any Medication? Y or N

If yes please list: ____

WOMEN ONLY:

Are you currently pregnant? Y or N

Have your past pregnancies been normal? Y or N

Are you seeing an OB/GYN regularly? Y or N

If yes: Name: ________________________ City/State: ____________________

Phone: ________________________

Date of Last Physical Exam: ______________

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Which of the following conditions do you now have or have you previously had?

Arthritis	Never	Previously Had	Currently Have
Asthma	Never	Previously Had	Currently Have
Sinus Issues	Never	Previously Had	Currently Have
Hay Fever	Never	Previously Had	Currently Have
Allergies	Never	Previously Had	Currently Have
Tuberculosis	Never	Previously Had	Currently Have
Diabetes	Never	Previously Had	Currently Have
Epilepsy	Never	Previously Had	Currently Have
Thyroid Problem	Never	Previously Had	Currently Have
High Blood Pressure	Never	Previously Had	Currently Have
Low Blood Pressure	Never	Previously Had	Currently Have
Heart Trouble	Never	Previously Had	Currently Have
Pacemaker	Never	Previously Had	Currently Have
HIV	Never	Previously Had	Currently Have
AIDS	Never	Previously Had	Currently Have
STD	Never	Previously Had	Currently Have
Ulcer	Never	Previously Had	Currently Have
Cancer	Never	Previously Had	Currently Have
Polio	Never	Previously Had	Currently Have
Rheumatic Fever	Never	Previously Had	Currently Have
Serious Injury	Never	Previously Had	Currently Have
Bone Fracture	Never	Previously Had	Currently Have
Dislocated Joints	Never	Previously Had	Currently Have
Spinal Disc Desease	Never	Previously Had	Currently Have
Multiple Sclerosis	Never	Previously Had	Currently Have
Scoliosis	Never	Previously Had	Currently Have
Mental/Emotional Disturbance	Never	Previously Had	Currently Have
Prostate Problem	Never	Previously Had	Currently Have
Kidney Problem	Never	Previously Had	Currently Have

Other: ____

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Family History:

	Cancer	Diabetes	High Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sister 1									
Sister 2									
Brother 1									
Brother 2									
Child 1									
Child 2									
Other									
Other									

Please describe any other conditions that may run in your family: ________________________

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Occupational Information:

Job type: (Circle) Full Time Part Time Temporary Unemployed Other

Hours Worked per week: __________ Days per week: __________

How long with current employer? ____________________

Does your present complaint affect the number of hours you work per day/week? Y or N

If yes, please describe: ____

Does your job involve lifting? Y or N

If yes, how many pounds and describe: ____

What is your primary position at work? (Circle)

Standing Seated Other: ___________________________

Desk Workbench Counter

If seated, what type of chair? (Circle) Executive Stool Bench Steno Other: __________