Health & Wellness Center PSL
433 NW Prima Vista Blvd., Port St. Lucie, FL 34983
Phone: (772) 336-1770 Fax: (772) 336-1160

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

_____ **Today's Date**

Security Question: ***Name of favorite Pet or Name of City you where born in?***
(must be 6 characters or more long)
Choose one of above: _____

_____
Who may we thank for referring you? **Gender ○Male ○Female** **Social Security number**_____

_____ **Preferred Language:**_____
Your Last Name

_____ _____ _____
Your First Name **Your Middle Name (or initial)** **Birth Date**

_____ **Marital Status**
○Single ○Married ○Divorced
_____ **○Widowed ○Separated ○Partnered**
Address

_____ _____ _____ _____ _____
City **State** **ZIP/Postal Code** **Home Phone** **Cell Phone**

_____ _____
Email Address **Spouse's Name**

_____ _____
Emergency Contact **Phone**

_____ **I give permission to be contacted by:**
Phone **○ Phone ○ Mail ○ Email**

_____ **Race/Ethnicity:** **○Caucasian**
Your Occupation **○Black/African American ○ Asian**
○Hispanic ○ I choose not to specify
_____ _____ **○Other**_____
Your Employer **Work Phone**

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Health & Wellness Center/Dr. Lare Ziemba or Dr. Chris Snyder, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This office may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. A copy of our office HIPPA form is available at your request.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

DATE:_____ **Relationship to Patient:**_____

Patient Name:_____ **Date**_____

1. The symptoms that have prompted me to seek care today include: _____

_____

2. And are the result of ○ **An accident** ○ **Work** ○ **Auto** ○ **Other** _____

○ **A worsening long-term problem EXPLAIN:** _____

3. When did you first notice your current symptoms? _____

4. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

5. Duration and Timing (When did it start and how often to you feel it?) ○ **Constant** ○ **Comes and goes** ○ **Occasional**

Explain? _____

6. Quality of symptoms (What does it feel like?) ○ **Numbness** ○ **Tingling** ○ **Stiffness** ○ **Dull** ○ **Aching** ○ **Cramps** ○ **Nagging** ○ **Sharp** ○ **Burning** ○ **Shooting** ○ **Throbbing** ○ **Stabbing** ○ **Other** _____

7. Radiation (Does it affect other areas of your body? (To what areas does the pain radiate, shoot or travel? Arm, leg, hand, etc.)

_____

8. Aggravating factors (What worsens the problem?) (Mark *all that apply*) ○ **Sitting** ○ **walking** ○ **bending** ○ **sleeping** ○ **lifting** ○ **movement** ○ **household chores** ○ **exercise** ○ **driving** ○ **shopping** ○ **dressing** ○ **reaching** ○ **yard work** ○ **other:**

_____

9. Relieving factors (What tends to lessen the problem) (Mark *all that apply*) ○ **Sitting** ○ **standing** ○**lying down** ○ **rest** ○ **no movement** ○ **stretching** ○ **ice** ○ **heat** ○ **medication** ○ **massage** ○ **topical ointment** ○ **other:**_____

10. Prior interventions (What have you done to relieve the symptoms?) ○ **Prescription medication** ○ **Surgery** ○ **Ice** ○ **Heat** ○ **Over the counter drugs** ○ **Homeopathic remedies** ○ **Physical therapy** ○ **Acupuncture** ○ **Massage** ○ **Chiropractic** ○ **Other :**_____

11. Have you had an x-ray, MRI, CT Scan on your back or neck ○ **No** ○ **Yes** **When ?**_____

12. Does your current condition interfere with : ○ **Work** ○ **Recreational Activities** ○ **Household responsibilities** ○ **Personal relationships** ○**Sports/ golf** ○ **Other:** _____

Review of Systems: **Chiropractic care focuses on the integrity of your nervous system, which controls your entire body. Please darken the circle beside any condition that you've *Had* or currently *Have*.**

Neurological	**Cardiovascular**	**Respiratory**	**Musculoskeletal**	
○Anxiety	○High blood pressure	○Asthma	○ Osteoporosis	○Arthritis
○Depression	○Low blood pressure	○Apnea	○Knee pain	○Scoliosis
○Headache	○High cholesterol	○Emphysema/COPD	○Hip pain	○TMJ issues
○Dizziness/vertigo	○Poor circulation	○Allergies	○Foot/Ankle Pain	○Elbow/wrist
○Pins & Needles	○Angina	○Shortness of breath	○Neck pain	○Poor Posture
○Numbness	○Swelling ankles/feet	○Air hunger	○Shoulder problems	
○Seizures	○Anemia	○Cough	○Back pain	level
○Tremors	○Murmur		○**Herniated/Bulged discs**_____	
Sensory	**Integumentary**	**Digestive**	**Ears/ Nose/ Throat**	
○Blurred Vision	○Skin cancer	○Anorexia/Bulimia	○Bleeding gums	
○Ringing in ears	○Psoriasis	○Ulcer/stomach pain	○Sinuses	
○Hearing loss	○Eczema	○Nausea/ vomiting	○Frequent sore throat	
○Chronic ear infection	○Acne	○Heartburn/reflux	○Swollen glands	
○Loss of smell	○Hair loss	○Constipation	○Earaches/ hearing loss	
○Loss of taste	○Rash/itching	○Diarrhea	○Mouth sores	

Patient Name:_____ **Date**_____

Please darken the circle beside any condition that you've *Had* or currently *Have*.

Endocrine	**Genitourinary**	**Constitutional**	**Women only**
○Thyroid __hypo/ __ hyper	○ Kidney stones	○Fainting	○Irregular periods
○Immune disorders	○Infertility	○Low libido	○Painful periods
○Hypoglycemia	○Bladder incontinence	○Poor appetite	○Vaginal discharge
○Fibromyalgia	○Prostate Issues	○Fatigue	○Pregnancy
○Swollen glands	○Erectile dysfunction	○Insomnia	○Breast pain/ lump
○Systemic Lupus	○Frequent urination	○ Sudden weight change __ loss__gain	

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. ***Please complete each section fully.***

Illnesses

Check the illnesses you have ***Had*** in the past or ***Have*** now.

○ HIV	○Epilepsy	○Malaria	○Rheumatoid arthritis	Other_____
○Alcoholism	○Glaucoma	○Measles	○Scarlet or rheumatic Fever	○
○Allergies	○Goiter	○Multiple Sclerosis	○Sexually transmitted disease type_____	
○Arteriosclerosis	○Gout	○Mumps	○Stroke	
○Tuberculosis	○Heart Disease	○Parkinson's	○**Cancer- Type**_____	
○Chicken Pox	○Hepatitis	○Polio	○**DIABETES –is A1C checked - Yes___ No ___ AIC-Number**_____	

Accident/ falls/ injuries- describe (Past or recent)_____

_____

Operations

Surgical interventions, which may or may not have included hospitalization.

○ Appendix removal	○ Hysterectomy	○ **Joint Replacement** _____
○ Heart Bypass surgery	○ **Pacemaker**	○ **Spine** _____
○ Gallbladder removed	○ Tonsillectomy	○ **Cancer- Type**_____
○ Elective	○ Vasectomy	○ **Arthroscopic**_____
○ Eye cataracts	○ **Other**_____	

Family History - Some health issues are hereditary**. List any conditions or diseases of your immediate family members.**
(Examples- diabetes, thyroid, arthritis, depression, cancer, hypertension, stroke, heart disease, liver disease, autoimmune, asthma, anemia etc.)

Mother- _____
Father- _____
Siblings- _____
Grandparent- _____

Social History - Tell Dr. Ziemba about your health habits and stress levels. *Please check if appropriate.*

○Alcohol Use _____ drinks per day / week / month
○Caffeine Use _____ drinks per day/ week/ month
○Exercising _____ times per week/ month

TOBACCO USE___ NEVER Smoked____ Ex-smoker ____ Smoke
If you smoke, are you interested in quitting? _____YES _____ NO
How many packs per day_____ pack/ or _____Occasional smoker

M E D I C A T I O N S: (Prescriptions and over-the-counter)

Drug name	**Strength/ MG**	**frequency (times per day)**

ALLERGIES TO M E D I C A T I O N S: ___Yes ___No List: _____

_____

Previous / other Health Care Providers you have seen in last 5 years:

Name	Type of Physician	Problem cared for	still seeing
_____			Yes / No
_____			Yes / No
_____			Yes / No