

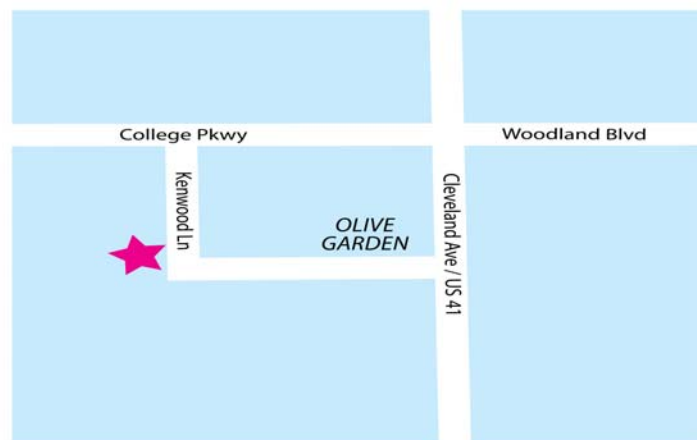
Welcome, we look forward to meeting with you at our Fort Myers office. We are located in Kenwood Park complex.

12734 Kenwood Lane, Suite 32 Fort Myers FL 33907

When you drive into Kenwood Park, we will be the third building on your right. Our front door is on the west side of the building, around the corner to your right.

Please bring the following forms completely filled out.

You can reach us at 239-274-8005.



Thank you



WELCOME

Patient Information

Date: _____

Name: _____ Email _____

(Your email will not be shared with any 3^d parties and is used for general office announcements, promotions and communication)

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ WK: _____ Hm: _____

Secondary address (for seasonal patients only) _____

City: _____ State _____ Zip _____

Social Security #: _____ Birth date _____ Marital Status: M S other

Emergency Contact: _____ Phone: _____ Relationship _____

Your Occupation _____ Employer _____

Who may we thank for referring you to our office? _____

Insurance Information *you are considered self-pay patient until we qualify and accept your insurance coverage.*

Payment for Services: Cash Check Credit Card Health Insurance Automobile Insurance

Insured's Employer: _____ Insured's Social Security: _____ DOB _____

Does more than one insurance company cover you? Yes No

Name: _____ Policy _____ Phone _____

Have you ever been under chiropractic care? Yes No

DC name _____

Who is your primary care physician? _____ City _____ State _____

Phone _____ Fax _____

By signing below, I authorize Southwest Spine & Sport, Inc. to release any healthcare information regarding treatment to my primary care provider.

Signature: _____ **Date** _____

Health History

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list dates of **any automobile accidents** you have been involved in: _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Other _____ |

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Patient Name: _____

Signature: _____ **Date** _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger Location Left Middle Right Other _____ Front Passenger
 Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____ MPH
 Moving Slowly

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

**Time of day:
compromised by:**

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

Patient Initials _____

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
- Aware that the accident was impending
- Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- Seat belt
- Shoulder harness
- No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

What position was YOUR headrest in?

- High position
- Middle position
- Low position

Position of YOUR head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your head thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left, then the right
- To the right To the right, then the left

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your body thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left
- Across the vehicle
- Outside the vehicle Under the vehicle

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Your Head

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Patient Initials _____

Right Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Torso

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
 No

Immediately following the accident, did you feel...?

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Weak |
| <input type="checkbox"/> Dazed | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Nauseated |

Were you able to walk unaided?

- Yes
 No

Where did you go...?

- | | |
|--|---|
| <input type="checkbox"/> Drove home | <input type="checkbox"/> Drove to work |
| <input type="checkbox"/> Was driven home | <input type="checkbox"/> Was driven to work |
| <input type="checkbox"/> Drove to hospital | <input type="checkbox"/> Drove to school |
| <input type="checkbox"/> Was driven to hospital | <input type="checkbox"/> Was driven to school |
| <input type="checkbox"/> Taken to hospital via ambulance | |

Next day discomfort...?

- increased decreased same

Did your major complaints exist before the accident?

- Yes No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|----------|---------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | <input type="checkbox"/> Pelvis | | | | |

Patient Initials _____

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

At the hospital, what areas were X-rayed?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

Was anyone else in the same car as you ? Yes No

Please list their names: _____

Patient Name: _____

Signature: _____ **Date** _____

Consent for Treatment:

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Consent of Treatment of a Minor Child

I hereby authorize Southwest Spine and Sport, Inc., physicians, therapists and employees to examine and / or treat my daughter / son.

Full name of child: _____

Parent Guardian Name _____

Signature _____ Date _____

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions regarding its content, and by signing below I agree to the above named procedures. I intend this consent form to cover treatment for my present condition, as well as all future conditions for which I seek treatment.

Patient Name: _____

Signature: _____ **Date** _____