

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Serenity Health Chiropractic
Bambi Denais DC, DICCP
60 2nd St., Unit C-7
Shalimar, FL 32579
PH: 850-613-4125
Fax: 850-613-4148
serenityhealthchiropractic.com

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Age
Gender
 Male Female

Race
 American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity
 Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married
 Single Divorced
 Widowed Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

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UPDATED PATIENT HISTORY

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I have new contact information

Today's Date (MM/DD/YYYY) _____

Patient Number
(office use only)

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation. **New condition** – I've been under care and a new or returning condition has emerged.
 Maintenance patient – I'm under maintenance care with a new or returning health issue. **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

- A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

- A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

- A worsening long-term problem
 An interest in: Wellness Other _____

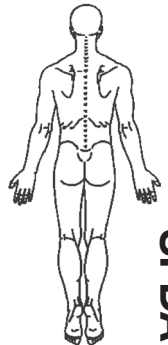
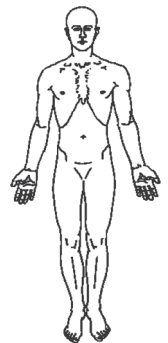
Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Location

(Where does it hurt?)
 Circle the area(s) on the illustration.
 "0" for current condition
 "X" for conditions experienced in the past



1. Review of systems (Identify any changes since your most recent evaluation with us):

- | | Worse | No Change | Improved |
|---|-----------------------|-----------------------|-----------------------|
| a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Doctor's Initials _____

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2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

3. Medications (please list all prescription and over-the-counter): _____

4. Social History (Tell Dr. Denais about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____

Coffee use Daily Weekly How much? _____

Tobacco use Daily Weekly How much? _____

Exercising Daily Weekly How much? _____

Pain relievers Daily Weekly How much? _____

Soft drinks Daily Weekly How much? _____

Water intake Daily Weekly How much? _____

Hobbies: _____

Prayer or meditation? Yes No

Job pressure/stress? Yes No

Financial peace? Yes No

Vaccinated? Yes No

Mercury fillings? Yes No

Recreational drugs? Yes No

5. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Is there anything else Dr. Denais should know about your current condition, your progress or ways your current condition is affecting your life?

Patient name

Patient Number
(office use only)

Consultation Notes

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Doctor's Initials

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