

Welcome to Gulf Coast Rehabilitation and Wellness Center

Patient Information

Kevin Lee, D.C.

Thank you for choosing Gulf Coast Rehabilitation and Wellness Center for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

Name: _____ (please print clearly)

Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: Female Male Birthdate: _____ Age: _____

E-mail: _____

Home Phone: _____ Cell: _____ Work: _____

Married Widowed Single Minor Separated Divorced Partnered

Patient Employer/School: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Referred by whom/place? _____

Emergency contact: _____ Phone: _____

Insurance Co: _____

Phone: _____ Group # _____

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security# _____

Employer: _____ Phone: _____

Have you had previous Chiropractic Treatment? Yes No What? _____

Reason for visit today: _____

When did you first notice the symptoms? _____

Are your present problems due to an injury or an accident? No Yes

If yes, type of accident? Auto accident On the job Personal injury Other _____

Has the accident been reported? No / Yes: Insurance Co. Police Employer

Is the condition getting progressively worse? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning

Tingling Cramps Stiffness Swelling Other Constant Pain Comes and goes

What treatment have you received for your condition? Medication Surgery Physical Therapy

Other _____

HABITS

Smoking Packs/Day:

Drinking Alcohol

Coffee

EXERCISE

None

Moderate

Daily

Type _____

FAMILY HISTORY

Diabetes Heart Kidney Cancer

Mother

Father

Brother, # of ____

Sister, # of ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

541 Appendicitis

480 Pneumonia

390 Rheumatic Fever

045 Polio

011 Tuberculosis

033 Whooping Cough

280 Anemia

055 Measles

072 Mumps

052 Chicken Pox

250 Diabetes

239 Cancer

429.9 Heart Disease

240 Goiter

487 Influenza

511 Pleurisy

305.0 Alcoholism

099 Venereal Disease

716 Arthritis

345 Epilepsy

319 Mental Disorder

724.2 Lumbago

690 Eczema

044 HIV Positive

Primary Care Doctor (MD/DO): _____

Dates/reasons of last exams: _____

Health History Check only those conditions which are applicable:

Please check the correct box for each item below . Check one box for each sign or symptom listed. Never Previously Presently

Never	Previously	Presently	GENERAL SYMPTOMS		Never	Previously	Presently	GASTRO-INTESTINAL		Never	Previously	Presently	EYE/EAR/NOSE/THROAT		Never	Previously	Presently	RESPIRATORY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	905.3	Allergies (w hat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787	Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	493.9	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.50	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	789.0	Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	378.9	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	491	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	564.0	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	389.9	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.09	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.9	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	558.9	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.7	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.3	Spitting blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.3	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.6	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.6	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.4	Spitting phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.4	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	575.9	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.30	Ear noises					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.2	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	455.6	Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	240.9	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITO-URINARY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.7	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.4	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	460	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.3	Bet Wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.6	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	794.8	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	477.9	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	599.7	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.0	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.0	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.49	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.4	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.52	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8	Pain over Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	478.1	Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.3	Inability to Control Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783	Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.0	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.7	Nose Bleeds					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	799.2	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8	Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	379.91	Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	590.9	Kidney Infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	729.2	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.0	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.1	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.8	Night Sw eats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	578.0	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	473.9	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	601.9	Prostate Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782	Numbness or Pain in arms/legs/hands						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	462	Sore Throats					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.09	Wheezing						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	463	Tonsillitis					
			MUSCLES & JOINTS					CARDIO-VASCULAR					SKIN OR ALLERGIES					FOR WOMEN ONLY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	724.5	Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	401.9	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	690	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	625.3	Cramps or Backaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.7	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	458.9	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	924.9	Bruising Easily					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	550.0	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.51	Pain over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	701.1	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	626.2	Excessive Flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.1	Pain Betw een Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	785.9	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	691.8	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	627.2	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	724.6	Painful Tail Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	438	Previous Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	708.9	Hives or Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	626.4	Irregular Cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	723.9	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	785.0	Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	698.9	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	634.9	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.9	Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	427.89	Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.0	Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	625.3	Painful Periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.0	Sw ollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	436	Strokes				368.9	Skin Eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	623.5	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.0	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.3	Sw elling Ankles						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pregnant at this time?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.0	Tw itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	454	Varicose Veins								<input type="checkbox"/>		Last Menstrual Cycle

OPERATIONS AND PROCEDURES

I have never had any operations/ surgeries

DATE	DESCRIPTION	DATE	DESCRIPTION
	Vaccinations		Tubes in Ears
	Tonsillectomy		Appendectomy
	Gall Bladder		Female Organs
	Back Operation		Rectal Surgery
	(list other surgery)		(list other surgery)

List the dates for any accidents or falls: Auto _____ Sports _____
 Other _____

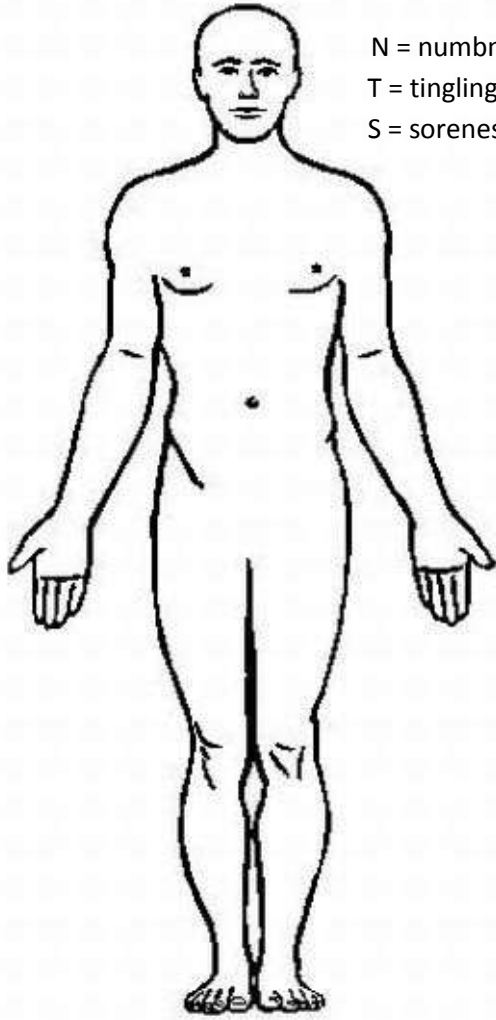
List any broken bones, fractures or dislocations: _____
 Ever been on crutches? _____ Why? _____
 Have you ever had any spinal taps or spinal injections? Yes No When? _____
 Have you ever been knocked unconscious? Yes No When? _____
 Have you ever had a lapse of memory? Yes No When? _____
 Have you ever had x-rays taken? Yes No When? _____
 Where were the x-rays taken and for what reason? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Kevin Lee, DC, 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. Kevin Lee, DC, 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.

X
 Patient/Guardian Signature _____ Date _____

Date _____ Name _____

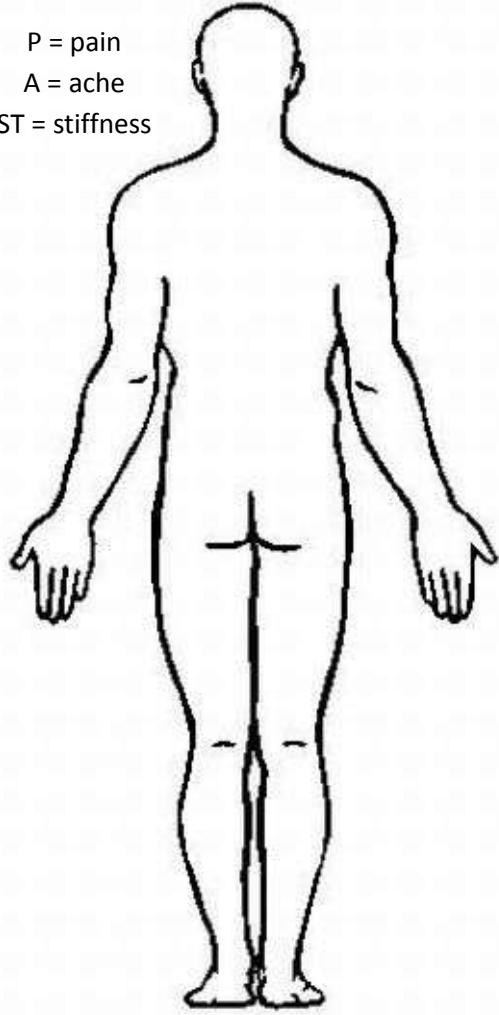
Please mark area and type of pain on the drawings using the codes listed.



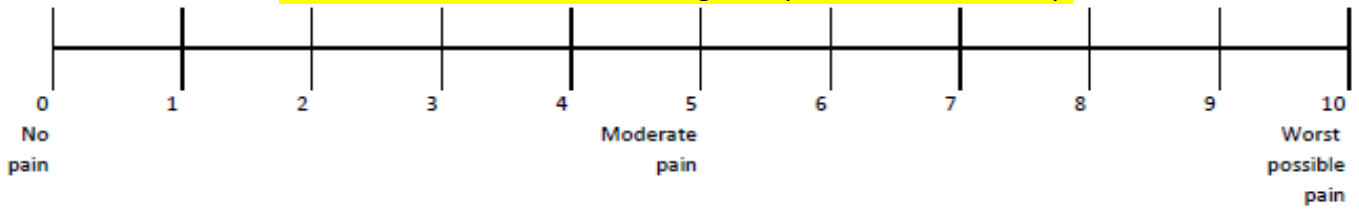
N = numbness
T = tingling
S = soreness

P = pain
A = ache
ST = stiffness

H = headache



Please circle a number describing how you feel overall today.



DOCTOR USE ONLY
