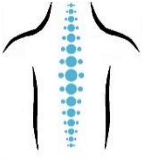
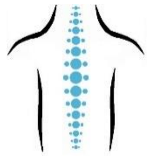


Fulp Spinal Wellness Center, LLC

1495 Kennedy Road ◊ Tifton, GA 31794
(229) 402-7833



Doctor ____________________________ **ID #** ___________________

PATIENT SCREENING FORM

Please provide the following information so that we can develop and provide the most accurate care plan for you.

PLEASE PRINT Today's Date ____/_____/_____

Legal Name: (Last) ________________________________ **(First)**____________________________ **(MI)**______________

Address:____ **City:**____________________ **State:**______ **Zip:**_________

Birth Date: ________________ **Sex:** M / F **Social Security:**_________________________ **Marital Status:** S M D W

Home # (_______)_________________ **Cell #** (_______)________________ **Email**_____________________________________

Age:______ **Height:** _____ ft. _____ in. **Weight:** _________ lbs. **Occupation:** __________________________

Employer:____ **Number of years at current job:**________

Person to contact in case of emergency: Name: ____

Relationship :______________________________________ Phone: (______)__________________________

Who can we thank for your Referral? ____

Is todays visit related to a work and/or an auto accident?	☐ **Yes** ☐ **No**
Are you currently in litigation for any accidents? (Auto, Worker's Comp, etc.)	☐ **Yes** ☐ **No**
Have you been advised to restrict activities by any other Health Care Provider?	☐ **Yes** ☐ **No**
Female Patients: Is there any possibility you are pregnant?	☐ **Yes** ☐ **No** **If yes, how many weeks** _____

Are you currently being treated for any major diseases or illnesses? Y / N If yes, What?__________________________

MEDICAL HISTORY: ***Please check all that apply below.***

☐ High Blood Pressure	☐ History of Seizures	☐ Sjogren's Syndrome	☐ Bipolar Disorder
☐ History of Stroke(s)	☐ Diabetes	☐ Lupus	☐ Schizophrenia
☐ History of Blood Clots	☐ Thyroid Disease	☐ Osteoarthritis	☐ Depression
☐ Aneurysm	☐ Kidney Disease	☐ Osteoporosis	☐ PTSD
☐ Heart Problems	☐ Musculoskeletal Disease	☐ Disc Herniation	☐ Implants / Orthotics
☐ Lung / Breathing Problems	☐ Rheumatoid Arthritis	☐ Allergies	☐ Spinal Fracture/Fusion
☐ Cancer / Tumor	☐ Ankylosing Spondylitis	☐ Migraine Headaches	☐ Neurological Disorder

Other:

(Men over 50) When was your last prostate exam? ___/___/___

(Women over 40) When was your last Mammogram? ___/___/___

Do you use tobacco products? Y / N **IF Yes:** What form?_____________ How Long?_________ How much daily? _______

Are you currently taking any Medications, Supplements, or Recreational Drugs? Y / N

If yes: Please List them: ____

____

____

Please list any previous accidents, injuries, surgeries, ER visits, hospitalization(s)

Date ___/___/___ Occurrence: ____

Date ___/___/___ Occurrence: ____

Date ___/___/___ Occurrence: ____

Date ___/___/___ Occurrence: ____

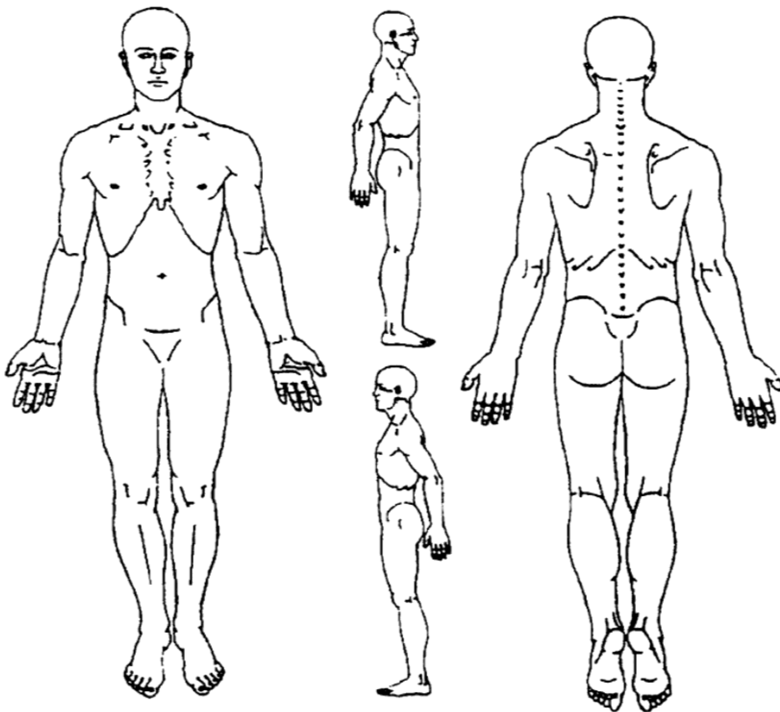
Date ___/___/___ Occurrence: ____

Have you ever had Chiropractic Care before? Y /N

If yes, When:____________________ Where:________________________________ Reason:____________________

Why are you seeking Chiropractic Care today? ____

Circle area(s) on the figure below where you experience pain.



- **When did the pain start ?** ________________
- **How did the pain start ?** ________________
  ____
- **Describe the pain.** ________________________
  ____
- **Rate the pain now.** (Circle one)
  LEAST **0 1 2 3 4 5 6 7 8 9 10** WORST

Circle additional symptoms / complaints below	
Numbness	Abdominal Pain
Tingling	Nausea
Chest Pain	Dizziness
Shortness of breath	Fainting
Diarrhea	Ear Aches
Constipation	Blurred Vision
Urinary Problems	Night Sweats
Other:	

Date of Last X-ray(s) ____/_____/_____ Areas of X-ray(s): ☐ Neck ☐ Thoracic ☐ Lumbar ☐ Other: __________

Where were X-rays taken?____

FAMILY HISTORY: CIRCLE THE FAMILY MEMBER(S) FOR EACH CONDITION ANSWERED YES

Y / N Diabetes Type: __________________________

MOTHER FATHER BROTHER(S) SISTER(S)

Y / N High blood pressure

MOTHER FATHER BROTHER(S) SISTER(S)

Y / N Rheumatoid arthritis

MOTHER FATHER BROTHER(S) SISTER(S)

Y / N Blood clot

MOTHER FATHER BROTHER(S) SISTER(S)

Y / N Cancer Type:____________________________

MOTHER FATHER BROTHER(S) SISTER(S)

Y / N Musculoskeletal Disease Type:____________

MOTHER FATHER BROTHER(S) SISTER(S)

Other family history:

I have reviewed and certify that all of the information that I have reported above is true and accurate the best of my knowledge.

Patient Signature ____ Date ____/____/_____

Legal guardian signature if patient is a minor