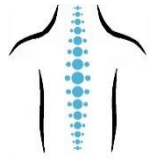


Fulp Spinal Wellness Center, LLC

114 W 12th St Suite F ♦ 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 today's 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.

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

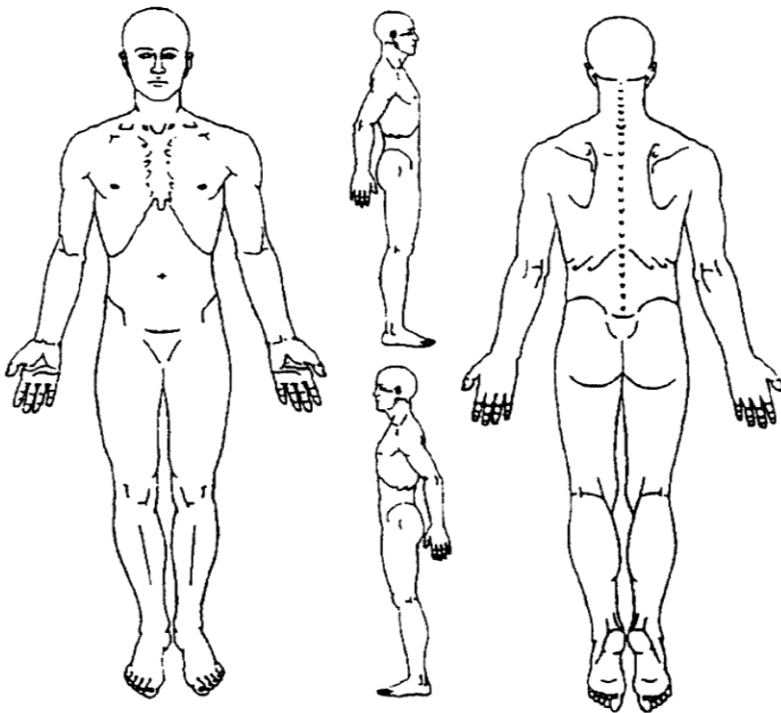
Date ___/___/___ Occurrence: _____
 Date ___/___/___ Occurrence: _____
 Date ___/___/___ Occurrence: _____
 Date ___/___/___ Occurrence: _____
 Date ___/___/___ Occurrence: _____

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 _____