Fuller Chiropractic

Dr. Joseph E. Fuller & Dr. Nicholas J. Fuller

NO: __________ Date: _________

Name: ____
Last, First, MI

Phone Numbers: HOME: ____
CELL: ____
OFFICE: _______________________________________

Email: ____

Address: ____
____

Married: ______ Single: _____ Other: _____

Social Security Number: _________________________ Age: ________________

Date of Birth: _____/_____/_____

Occupation: ______________________________ Employer: _________________

In case of emergency, contact: ___________________________________

Relationship: ______________________ Phone Number: _________________

Previous Chiropractic Care? Yes/No Dr.'s Name: ____________________

Name of insurance company: ____

Referred by: ______________________________

Symptoms/Complaints: ____

Date of onset: _____/_____/ _____

Are you interested in:
Allergy treatment: _____ Acupuncture: ______
Nutrition Counseling: _____

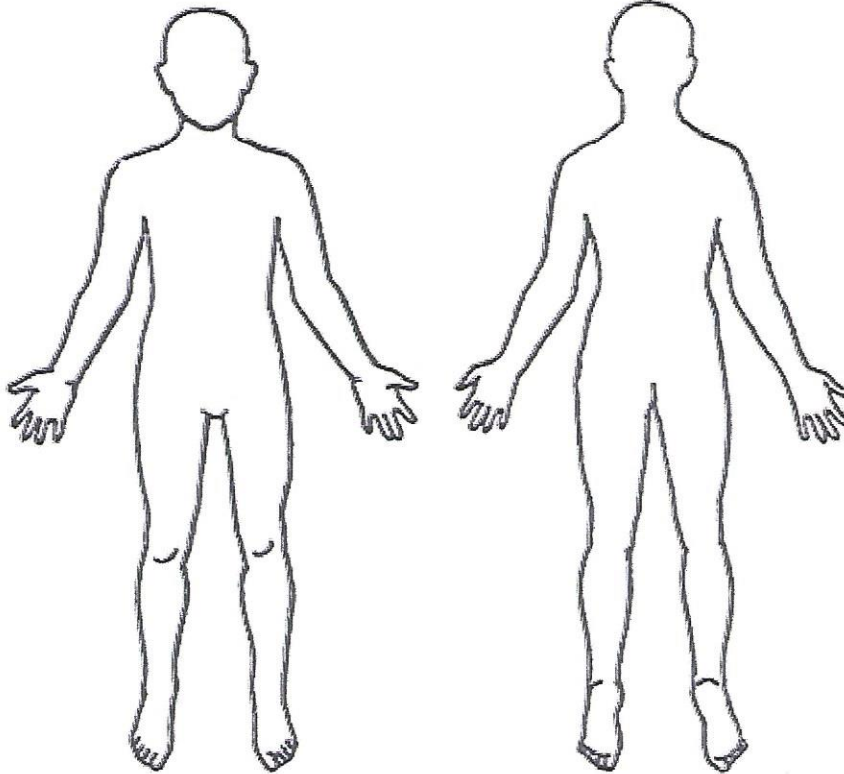
2111 Glenwood Drive, Suite 210
Winter Park, FL 32792
(407) 599-5555 Fax (407) 599-0692
www.fullerhealthcenter.com

PATIENT VISIT FORM

Name: ______________________________ Date:___________

Please mark the areas of the body where your pain is.

Also, rate the areas of pain on a scale of 1-10, 10 being the worst.



If you're an established patient, and your visit is to maximize health, check here:______
Do you have any new conditions/injuries? YES NO
Have you had any new accidents? YES NO

Additional comments to Dr. Fuller:

____

____

Patient Signature: ____________________________

FULLER CHIROPRACTIC

Medical History HT:_______ WT:_______ SEX: M/F
Name:______________________ Date:______________ DOB:______________

Health History of Patient

	YES	NO
STROKE		
HEART TROUBLE		
HIGH BLOOD PRESSURE		
DIABETES		
ARTHRITIS		
GOUT		
MENTAL ILLNESS		
KIDNEY TROUBLE/STONES		
CANCER		
BLEEDING DISORDER		
ALCOHOLISM		
SERIOUS INJURIES		
LUNG DISEASE		
TUBERCULOSIS		
PHLEBITIS		
ANEMIA		
STOMACH ULCERS		
LIVER TROUBLE		
HIV/AIDS		
THYROID TROUBLE		
OTHER ILLNESSES		

Explain All "YES" Answers
____
____
____

List all Surgeries (Appox. Dates)
____
____
____

Current Medications & Dosage
____
____
____

Allergies to Medicine None______
____

Family History

	YES	NO
STROKE		
HEART TROUBLE		
DIABETES		
ARTHRITIS		
GOUT		
SEIZURES		
MENTAL ILLNESS		
KIDNEY TROUBLE/STONES		
CANCER		
BLEEDING DISORDER		
ALCOHOLISM		
OTHER		

Explain All "YES" Answers
____
____
____

Cause of Death of Parents or Siblings
____
____
____

Social History
Occupation:______________________
Married____Single____Divorced____
Number of Children Living:________
Number of Pregnancies:________

	YES	NO
Presently Living Alone		

	YES	NO
Smoke?		

________ packs per day
Alcohol: Never____Occasional____
Moderate to Heavy ____

	YES	NO
Non-Prescription Drug Use		
Drug Addiction		
Current or Past		

Review of Systems

	YES	NO
READING GLASSES		
CHANGE OF VISION		
LOSS OF HEARING		
EAR PAIN		
HOARSENESS		
NOSEBLEEDS		
DIFFICULTY SWALLOWING		
MORNING COUGH		
SHORTNESS OF BREATH		
CHILLS OR FEVER		
HEART OR CHEST PAIN		
ABNOMAL HEARTBEAT		
BADLY SWOLLEN ANKLES		
CALF CRAMPIN WITH WALKING		
POOR APPETITE		
TOOTHACHE		
GUM TROUBLE		
NAUSEA OR VOMITING		
STOMACH PAIN		
ULCERS		
FRQUENT BELCHING		
FREQUENT LOOSE STOOLS		
BLOOD IN BOWEL MOVEMENTS		
FREQUENT CONSTIPATION		
HEMORRHOIDS		
FREQUENT URINATION		
BURNING ON URINATION		
DIFFICULTY STARTING URINATION		
DIFFICUTLTY STOPPING URINATION		
GET UP EVRY NIGHT TO URINATE		
FREQUENT HEADACHES		
BLACKOUTS		
SEIZURES		
FREQUENT RASH		
HOT OR COLD SPELLS		
RECENT WEIGHT CHANGE		
NERVOUS EXHAUSTION		

WOMEN ONLY:	YES	NO
IRREGULAR PERIODS		
VAGINAL DISCHARGE		
ARE YOU PREGNANT?		
ARE YOU NURSING?		

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Health Information Consent for Purpose of:
Treatment, Payment, and Healthcare Operations.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Fuller Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct the health care operations of Fuller Chiropractic. I understand that Dr. Joseph E. Fuller or Dr. Nicholas J. Fuller may refuse to diagnose or treatment if I do not consent to the use or disclosure of my protected health information for the above stated purpose. (My signature on this document is evidence of this consent.)

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carryout treatment, payment, or healthcare operations of the practice. Fuller Chiropractic is not required to agree to the restrictions that I may request. However, if Fuller Chiropractic agrees to a restriction that I request, the restriction is binding on Fuller Chiropractic, Dr. Joseph E. Fuller, or Dr. Nicholas J. Fuller.

I understand I have the right to review "The Fuller Chiropractic Notice of Privacy Practices" prior to signing this document. "The Fuller Chiropractic Notice of Privacy Practice" has been provided to me. The Notice of Privacy Practices describes the type of issues and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Fuller Chiropractic. The Notice of Privacy Practices for Fuller Chiropractic is provided to me on request at the main administrative desk of the practice. Fuller Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may retain a revised notice of privacy practices by calling Fuller Chiropractic and requesting a revised copy or by asking for one on my next appointment.

I have the right to revoke this consent, in writing, at any time except to the extent if Fuller Chiropractic, Dr. Joseph E. Fuller or Dr. Nicholas J. Fuller. Has taken action to reliance on this consent.

____
Signature of Patient or Personal Representative

____
Date

____
Printed Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

This document is meant to come into compliance with the HIPPA Federal guidelines concerning patient privacy and record keeping.