Spring Hill Chiropractic & Wellness
10543 Chalmer St Spring Hill, FL 34609

Confidential Entrance Application

(To best serve you, please fill out as completely as possible)

Dr. Michael E. Burr, DC
Dr. James Batson, DC

Date _____

Name _____

Address _____

City _____ State ____ Zip _____

Date of Birth _____ Age _____

Email (clearly please) _____

Whom may we thank for referring you to us? _____

I authorize your office to contact me via the above for appointment texts, general communication, products, services, promotions, special events, health topics, etc.

Best Phone Number _____

Married ____ Single ____ Name of Spouse / Partner _____

Medicare Coverage ___Yes ___No Insur. Co.:_____

Occupation _____ Employer _____

Signature _____

You/Family history- stroke/heart attack/vascular disease? Yes ____ No ____

Smoking History? Heavy / Mild Use Birth Control Pills? Yes ____ No ____

List dates- surgeries, significant trauma or history: _____

_____

_____

Top Reason for today's visit:_____

Do you think your cause of pain is : DISC __ MUSCLE __ JOINT __

NERVE __ INFLAMMATION __ OVERWEIGHT __ WEAR & TEAR __

Areas of interest: Less Pain__ Weight Loss__ Neuropathy__ Disc Decompression__

List all medications and over the counters you are taking. Medication:_____Medication:_____Medication:_____

Have you ever been to a chiropractor? Yes ____ No ____ Last Visit _____ Results _____

Any diagnostics for this condition? MRI: X-rays: Other: Other doctors consulted for this?

Treatments received for this condition? Medications Over the counters Physical Therapy Chiropractic Injections Surgery Muscle Treatment Other:

How important is getting help with your current condition to you? 1(low) - 10(high): _____ Hobbies:

Have you been told that you have Disc Degeneration, Bulging/Herniated Discs or other disc conditions? Yes__ No__

What types of care are you interested in?

RELIEF CARE __ REPAIR/CORRECTIVE CARE __ WELLNESS CARE __ What the DOCTOR RECOMMENDS __

History of: (check all that apply)

__ Arthritis or concerns of
__ Diabetes or Higher Blood Sugar
__ Cancer:
__ Fractures:
__ Disc Problems
__ Headaches
__ Osteoporosis
__ Joint Stiffness
__ Grating in the Neck or Back
__ Candida/Yeast problems
__ Head Feels Heavy or Dizziness
__ Muscle Spasms
__ Neck Pain/Mid Back Pain
__ Low Back Pain
__ Fibromyalgia or Reoccurring Body Pain
__ Lumps / Masses
__ Weight Gain
__ Abnormal Weight Loss
__ Numbness / Tingling
__ Fever
__ Weakness / Fatigue
__ Loss of Sleep
__ Muscle Pain
__ Bladder / Bowel Control
__ Knee Pain
__ Bloating/Constipation/Diarrhea/Gas
__ High Blood Pressure / Stroke / Heart
__ Aortic or Abdominal Aneurism
__ Alcohol, Smoke, Drug, Food Abuse
__ Arterial Sclerosis / High Cholesterol
__ Swelling / Inflammation

Any other conditions that you have been diagnosed with. Also, any significant family health history: _____

_____

What is most important element for you in deciding to use our services? Circle **ONLY ONE** of the four.

EFFECTIVENESS: "My results are my top priority" TIME: "I want results quickly" AFFORDABILITY: "What you charge is my concern" SERVICE: "Extra support for health"

I understand that my entire patient record will remain completely confidential and will not be released without express written consent from me. Fees for services are due and payable at the time of service, unless other arrangements have been made. I have received and agree to the current copy "Notice of Privacy Practices".

Signature _____ Date _____

Patient Name /Date _____ PLEASE USE 1 BOX PER SYMPTOM

#1 Primary Symptom (choose one below)

Choose ONLY 1 of 8 below:

1.__ Headache

2.__ Neck Pain

3.__ Left __ Right Arm Pain

4.__ Mid / Upper Back Pain

5.__ Low Back Pain

6.__ Left __Right Leg Pain

7.__ Hip Pain 8.Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:_____

When it is at its Worst 0-10:_____

Please check all that apply:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

1st Started: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

#2 Second Symptom (choose one below)

Choose ONLY 1 of 8 below:

1.__ Headache

2.__ Neck Pain

3.__ Left __ Right Arm Pain

4.__ Mid / Upper Back Pain

5.__ Low Back Pain

6.__ Left __Right Leg Pain

7.__ Hip Pain 8.Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:

When it is at its Worst 0-10:

Please check all that apply:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

Onset: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

#3 Third Symptom (choose one below)

Choose ONLY 1 of 8 below:

1.__ Headache

2.__ Neck Pain

3.__ Left __ Right Arm Pain

4.__ Mid / Upper Back Pain

5.__ Low Back Pain

6.__ Left __Right Leg Pain

7.__ Hip Pain 8.Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:

When it is at its Worst 0-10:

Please check all that apply:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

Onset: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

Doctor:

Patient Name _____ Date _____

#4 Fourth Symptom *(choose one below)*

__ Headache

__ Neck Pain

__ Left __ Right Arm Pain

__ Mid / Upper Back Pain

__ Low Back Pain

__ Left __Right Leg Pain

__ Hip Pain

Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:

When it is at its Worst 0-10:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

1st Started: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

#5 Fifth Symptom *(choose one below)*

__ Headache

__ Neck Pain

__ Left __ Right Arm Pain

__ Mid / Upper Back Pain

__ Low Back Pain

__ Left __Right Leg Pain

__ Hip Pain

Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:

When it is at its Worst 0-10:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

1st Started: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

#6 Sixth Symptom *(choose one below)*

__ Headache

__ Neck Pain

__ Left __ Right Arm Pain

__ Mid / Upper Back Pain

__ Low Back Pain

__ Left __Right Leg Pain

__ Hip Pain

Other:

0 = No Pain 5 = Moderate 10 = Intense

Severity Right Now 0 -10:

When it is at its Worst 0-10:

__ Occasional __ Intermittent

__ Frequent __ Constant

__ Dull __ Sharp

__ Burning __ Stiffness/Tightness

__ Ache __ Throbbing

__ Shooting __ Numbness

__ Tingling __ Spasms

1st Started: __ Days __ Weeks

__ Months __ Years

Cause(s):

What Aggravates It / Limitations:

__ Nothing __ Lying Down

__ Standing __ Sitting

__ Movement __ Rest

__ Coughing __ Sneezing

__ Getting out of bed __ Bending

__ Stress __ Stairs

__ Getting up from sit __ Walking

__ In/Out of car __ Lifting

__ Sleeping __Work

__ Recreation __ Reaching

__ Reading __ Social Life

What Relieves It?

It's Getting __ Better __ Worse __ Same

Doctor: