

# Dr. Craig J. Benton

Suncoast Chiropractic and Acupuncture, P.A.

Suncoast Wellness Club

687 Tamiami Trail • Port Charlotte, FL 33953 • (941)743-9904

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Female  Male Social Security # \_\_\_\_\_

Height:  Feet  Inches Weight: \_\_\_\_\_ lbs.

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you employed?  Yes  No  Retired

Are you on disability?  Yes  No Reason: \_\_\_\_\_

Workman's Compensation?  Yes  No Reason: \_\_\_\_\_

Seeking treatment for a motor vehicle accident?  Yes  No

Referred by: \_\_\_\_\_

## Reasons for seeking chiropractic care:

Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Location of Complaint: \_\_\_\_\_

Complaint Began when \_\_\_\_\_ and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

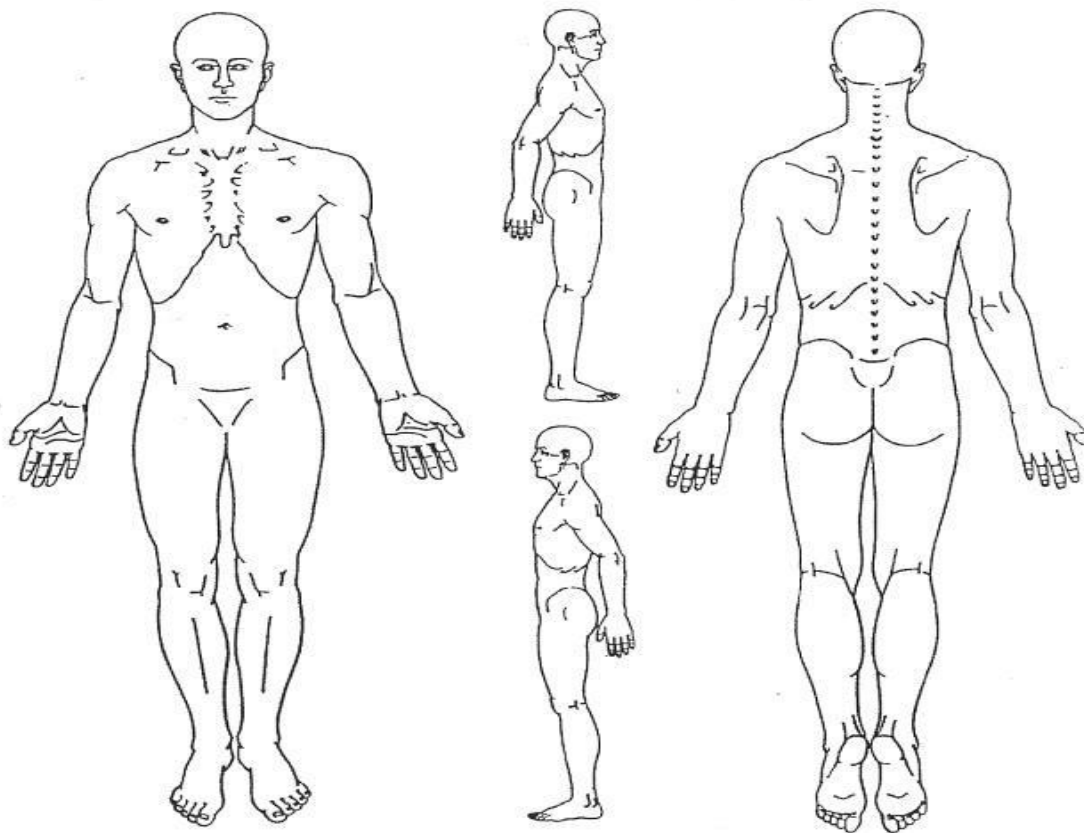
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On the diagram below, please indicate where you are experiencing pain, right now. please complete both sides of this form.



A = ACHE  
O = OTHER

B = BURNING  
S = STABBING

N = NUMBNESS  
P = PINS & NEEDLES

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### Treatment History:

Treatment	Yes	No	Helpful/Complications	Comments
Pain Management				
Physical Therapy				
Surgery				
Chiropractic				
Acupuncture				
Massage				
Other:				

Diagnostic Studies: (Related to today's visit)

Test	Yes	No	Date (if known)	Where/Findings
X-ray				
MRI				
CT-scan				
Other:				

### Medications:

Medication:	Why are you taking:

Allergies: \_\_\_\_\_

### Social History:

Do you smoke?  Yes  No If yes, How many a day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, How frequent? \_\_\_\_\_ What type? \_\_\_\_\_

Do you have a history of drug or alcohol addiction?  Yes  No

Marital status:  Single  Married  Separated  Divorced  Widowed  Other: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

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### Medical History:

In the last 3 months: (circle yes or no)

Yes	No	Heart attack	Yes	No	Diabetes
Yes	No	Angina	Yes	No	Thyroid problems
Yes	No	Irregular heart beat	Yes	No	Kidney disease
Yes	No	Heart murmur	Yes	No	Liver disease
Yes	No	High blood pressure	Yes	No	Cancer
Yes	No	Low blood pressure	Yes	No	Gallbladder problems
Yes	No	COPD	Yes	No	Arthritis
Yes	No	Asthma	Yes	No	Disc disorders (disc bulge, degenerative)
Yes	No	Stroke	Yes	No	Anti-coagulant therapy (blood thinner)
Yes	No	Headache	Yes	No	Visited hospital

### Surgical History:

Type of Surgery:	Date

### Injury or Traumatic History:

Have you ever been in a motor vehicle accident?  Yes  No If yes when? \_\_\_\_\_

If yes, injured?  Yes  No If yes, describe: \_\_\_\_\_

Have you had any other injuries or accidents?  Yes  No If yes, when and describe: \_\_\_\_\_

Have you broken any bones?  Yes  No If yes, which? \_\_\_\_\_

### Family History:

Relative	Age	Heart Disease	Cancer	T.B.	Diabetes	Age at death	Cause of death
Father		Yes	Yes	Yes	Yes		
		No	No	No	No		
Mother		Yes	Yes	Yes	Yes		
		No	No	No	No		
Sister(s)		Yes	Yes	Yes	Yes		
		No	No	No	No		
Brother(s)		Yes	Yes	Yes	Yes		
		No	No	No	No		

### **OFFICE USE ONLY:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_ Initials: \_\_\_\_\_