Patient Application

Please fill out the following information in its entirety to allow us the opportunity to better evaluate your case. If you have any questions, please feel free to ask one of our assistants. Thanks!

Patient Information:

Name: _____ **Preferred Name:** _____ **Date:** ___/___/____

□ **Male** □ **Female** **Birth Date:** ___/___/____ **SS#:** _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed **Anniversary Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

May we call you at work when necessary? □ Yes □ No **How many children do you have?** _____

Email Address: _____ **Religion (Optional):** _____

Occupation: _____ **Employer:** _____

Spouse: _____ **Phone:** _____

Mother: _____ **State:** _____ **Phone:** _____

Father: _____ **State:** _____ **Phone:** _____

Referred to Office by: □ Friend □ Family _____ □ Yellow Pages □ Mail □ Location

□TV □ Screening □ Paper/ Article / Report □ Radio □ Internet □ Other:_____

Payment for Services by: □Cash □Check □Credit Card □Health Insurance □Auto Insurance □Worker's Comp.

Type of Care Desired: □ Temporary Relief □ Lasting Correction

Would you like to receive appointment reminders? □ Yes □ No

-if yes, □ email □ text to cell phone (if yes, who is your service provider: _____)

Insurance Information:

Ins. Company Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Group # (Plan, Local, or Policy#): _____ **I.D. #:** _____

Subscribers Name: _____ **Subscribers SS#:** _____-_____-_____ **Relation:** _____

Date of Birth: ___/___/____ **Employer:** _____ **Years Worked:** _____

Health History:

Have You ever had any metal implants? □ Yes □ No

Have You ever been gun shot? □ Yes □ No

Have you been treated by a physician for any health condition in the last 12 months? □ Yes □ No

If Yes, please describe condition: _____

Surgical History:

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

Accident History:

□ **Job** □ **Auto** □ **Other:** _____ **Date:** _____

□ **Job** □ **Auto** □ **Other:** _____ **Date:** _____

□ **Job** □ **Auto** □ **Other:** _____ **Date:** _____

Major Complaints or Symptoms: What are you hoping we can help you with? Please rate them on a scale of 1 – 10 with *10 as the worst*.

□ blurred vision	____	□ dizziness	____	□ loss of balance	____	□ ringing in ears	____
□ buzzing ears	____	□ face flushed	____	□ loss of smell	____	□ shortness of breath	
□ cold feet	____	□ fainting	____	□ loss of taste	____	□ stiff neck	____
□ cold sweats	____	□ fatigue	____	□ low resistance to colds		□ stomach upset	____
□ concentration loss	____	□ fever	____	□ muscle jerking	____	□ None Present	
□ confusion	____	□ head seems too heavy		□ numbness in fingers	____		
□ constipation	____	□ headaches	____	□ numbness in toes	____		
□ depression/weeping spells		□ insomnia	____	□ pins/needles in arms	____		
□ diarrhea	____	□ light bothers eyes		□ pins/needles in legs	____		

Please Write Down Any Additional Symptoms You May Be Experiencing:

_____ **Rating:** ____ _____ **Rating:** ____

_____ **Rating:** ____ _____ **Rating:** ____

_____ **Rating:** ____ _____ **Rating:** ____

_____ **Rating:** ____ _____ **Rating:** ____

On a scale of 1-10, with 10 meaning "I'm serious about my health and I'm fully committed" what is your current level of commitment? 1 2 3 4 5 6 7 8 9 10

More Vital Information: Please describe your "worst" symptom(s)

When and how did the complaints or symptoms begin/occur? _____

_____

Symptoms developed from (please circle): job related, auto accident, illness, gradual onset or unknown cause

Symptoms have persisted for: ____ hour(s) ____ day(s) ____ week(s) ____ month(s) ____ year(s)

Sypmtoms □ Come and Go □ Are Constant □ Are Nearly Constant

Have you been treated by a medical physician for this condition before? □ Yes □ No

-If yes, where and by whom? _____

Are you taking any medications? □ Yes □ No If yes, what? _____

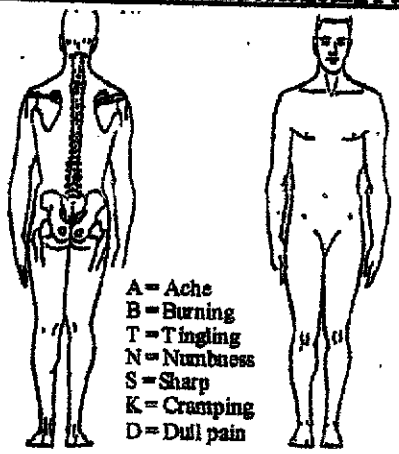
Are you allergic to any medications? □ Yes □ No If yes, what? _____

Please circle the motions that aggravate symptoms: □bending □coughing □lifting □lying down □reaching □sitting □sneezing □standing □straining at stool □turning head □other:_____

Please circle the motions that relieve symptoms: □bending □coughing □ lifting □ lying down □ reaching □ sitting □sneezing □standing □straining at stool □ turning head □ other: _____

Does your pain radiate? □ Yes □ No -If yes, where does it radiate to _____

Please Check the Areas of the Body Where You Are Experiencing Pain



Below, please circle the severity and intensity of your symptoms, at its worst:

Slight		Mild		Moderate				Severe	
□1	□2	□3	□4	□5	□6	□7	□8	□9	□10

On the scale below, please check the percentage of time that you experience your main complaints:

Occasional		Intermittent		Frequent				Constant	
□10%	□20%	□30%	□40%	□50%	□60%	□70%	□80%	□90%	□100%

Review of Systems: If yes, please describe the condition on the line provided.

Recent weight loss or weight gain (how much): □ Yes □ No _____

Rashes, hives or lesions: □ Yes □ No _____

Hay fever, sinuses or nasal discharge: □ Yes □ No _____

Chest pain or palpitations: □ Yes □ No _____

Shortness of breath, wheezing or coughing: □ Yes □ No _____

Nausea, vomiting or diarrhea: □ Yes □ No _____

Frequency with urination or urgency to urinate: □ Yes □ No _____

Lymphadenopathy (swelling of lymph nodes): □ Yes □ No _____

Polyuria or polydipsia (excessive thirst or urination): □ Yes □ No _____

History of seizures or headaches (how often): □ Yes □ No _____

Social History (please check):

Exercise	□Never	□Seldom	□Occasionally	□Regularly
Tobacco Usage	□None	□Light	□Moderate	□Heavy
Alcohol Usage	□None	□Light	□Moderate	□Heavy
Illegal Drug Usage	□None	□Light	□Moderate	□Heavy
RX-Drug Usage	□None	□Light	□Moderate	□Heavy

FEMALES ONLY:

Are you pregnant? □ Yes □ No
Are you taking Birth Control? □ Yes □ No
This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Steve Alukonis and his associates have my permission to perform an x-ray evaluation if there is need. I have been advised that x-rays can be hazardous to an unborn child.

Signature _____ **Date** _____/_____/_____

Family Health History

The reason for this form is to assist the doctor by providing past health history information for their review.

Condition Deceased Local	Self ☐ ☐	Father ☐ ☐	Mother ☐ ☐	Spouse ☐ ☐	Brothers ☐ ☐	Sisters ☐ ☐	Children ☐ ☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Low Back Trouble	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Hyperactivity/ ADHD	☐	☐	☐	☐	☐	☐	☐
Kidney Trouble	☐	☐	☐	☐	☐	☐	☐
Menstrual Cramps	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐	☐	☐
Numbness	☐	☐	☐	☐	☐	☐	☐
Pinched Nerve	☐	☐	☐	☐	☐	☐	☐
Poor Circulation	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐
Shoulder/Arm/Hand	☐	☐	☐	☐	☐	☐	☐
Sinus Trouble	☐	☐	☐	☐	☐	☐	☐
Stomach Trouble	☐	☐	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐	☐	☐

Dr. Steve Alukonis, DC, DABCO
299 North Orlando Avenue
Cocoa Beach, Fl 32931
(321)783-1960 Fax: (321)783-0058

Privacy Authorization for Space Coast Advanced Health

Dr. Alukonis and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health information is released or you may revoke your authorization to us at any time; however, you revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524).

This notice is effective as of April 2, 2013. This authorization will expire 7 years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner descibed. I also acknowledge that I have read and received a copy of the Space Coast Advanced Health's privacy policy.

_____ _____

Patient Signature Date

_____

Print Name

Dr. Steve Alukonis, D.C. DABCO
299 N. Orlando Avenue
Cocoa Beach, Fl 32931
Phone: 321-783-1960 Fax: 321-783-0058

Auto Accident History Report

Date: _____

Name: _____

Date of Accident: _____

Accident History

_____ Driver _____ Pedestrian _____ Passenger _____ Other

Traveling or stopped facing(circle one): North South East West

Location: Street: _____

City: _____

State: _____

Description Of Accident:

_____ Stopped/slowing down for red light/stop sign and was struck in the rear by another vehicle

_____ Was pushed into the vehicle in front of his/hers

_____ Slowing down to execute a left/right turn and was struck in the rear by another vehicle

_____ Was sideswiped by another vehicle traveling in the same direction

_____ Another vehicle traveling in th opposite direction collided head-on with his/her vehicle

_____ Another vehicle traveling in the opposite direction suddenly turned in front of his/her vehicle causing the two vehicles to collide.

_____ Another vehicle made an improper tun and caused the two vehicles to collide

_____ Another vehicle ran a red light/stop sign and struck his/her vechicle (broadside/rear/front)

_____ The vehicle in which he/she was riding was struck by another vehicle causing it to spin around/roll over

_____ The patient was involved in a multi-car collision

_____ The driver of the vehicle in which he/she was riding lost control and struck another vehicle/ran off the road/struck another (list object)

_____ The patient was thrown from the car to the pavement

_____ The patient was a pedestrian/riding a bicycle/riding a motorcycle and was struck by a motor vehicle

_____ Other (Brief description of accident)

Patients vehicle type: _____

Collsion with what type of vehicle: _____

Was the patient wearing a seat belt? Yes No

Did the airbag deploy? Yes No

Did he/she strike any object insde the car? Yes No
If yes, what objects were struck? _____

What body parts struck the object? _____

Was the patient: _____ unconcious _____ Cut or bleeding (decribe) _____

_____ Neither

Indicate the action take by the patient immediately following the accident:

_____ Went home and took it easy

_____ Went about normal business

_____ Went home and shortly after/later that night/the following morning began to experience pain in neck/back

_____ Went home and later drove/was driven to _____ by _____.

_____ Patient doctored him/herself thinking the pain would go away

_____ Went to a physician or hospital (Name of Dr/hospital) _____

Hospitilization:

Was patient seen in Emergency Room? Yes No If yes, ER _____

Was the patient admitted to the hospital? Yes No

Length of stay? _____

Name of admitting physician? _____

Indicate any procedure performed at the hospital (including the ER)

_____ Examination _____ X-Rays _____ Cervical Collar

_____ Blood Work _____ MRI/CT _____ Stitches

_____ Phsyical Therapy _____Injection _____ Wounds dressed

_____ Prescriptions _____Other: _____

Was the patient referred to another physician or sent for any diagnosic tests? Yes No
If yes, please decribe _____

Was the patient sent elsewhere for physical therapy? Yes No

Prior Accident and/or Injuries
Has the patient been involved in any previous accidents or injuries of any kind?

_____ No
_____ Yes (dates and details) _____

Past Medical History:
Does the patient have any significant medical problems? (Diabetes, high blood pressure)

_____ No
_____ Yes (please list) _____

Is the patient on any medications for medical problems?

_____ No
_____ Yes (please list) _____

Does the patient have any drug allergies?

_____ No
_____ Yes (please list) _____

Family History:

_____ Cancer _____ Rhematoid Arthritis _____ Diabetes

_____ Heart Problems _____ High Blood Pressure _____ Stroke

_____ Epilepsy/seizures _____Lupus _____
Other_____

Social History:

Marital Status: _____Single _____Married _____Divorced _____Widowed

Do you smoke Cigarettes? Yes (number of packs/day?) _____ No
Do you drink alcohol? Yes (number of drinks/week?) _____No
Do you use caffeine? Yes (number of drinks/week?) _____No

Gynecological History:

Are you pregnant? Yes No
Do you currently take birth control? Yes No

Present Complications:

What are the patient's present complaints (begin with the most severe)? Please note any numbness and/or tingling.

_____
_____
_____
_____

Is the patient currently taking medication(s) for pain/injuries resulting from accident/injuries?

_____
_____
_____

Disability:

Has the patient lost any time from work since the accident?
_____ Yes (number of days) _____ No
Is the patient still off froom work?
_____ Yes _____ No (date returned to work) _____

Is the patient working with any restrictions? If so, what? _____
_____

Current Occupation: _____ _____Full Time _____Part Time

Job Title: _____

Employer: _____

Patient Name: (Printed): _____

Patient Signature: _____

Date: _____

Doctor's Notes:

_____ Height _____ Weight _____ Blood Pressure _____ Pulse

_____

_____

_____

_____

_____