Medical History Information

Last Name:

First Name: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Widow

Email: Birth date: Age: Sex:

Address: City: State:

ZIP Code: Social Security No.: Home Phone:

Occupation: Employer: Employer phone:

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

Address: City: State: ZIP Code:

Date of last Visit: / / Date of last exam: / /

Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address: City: State: ZIP Code:

Date of last Visit: / / Date of last exam: / /

Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:

Reason for Surgery:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

HISTORY OF SYMPTOMS

Patient's Name: _____ Date: _____

HEADACHES	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Specifics	☐ Frontal ☐ Coronal ☐ Occipital ☐ Parietal ☐ Temporal ☐ Throughout
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Radiates to	☐ Neck ☐ Right Eye ☐ Left Eye ☐ Right Ear ☐ Left Ear ☐ Right Jaw ☐ Left Jaw
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bright lights ☐ Housework ☐ Loud noises ☐ Neck movements ☐ Watching T.V. ☐ Reading ☐ Working

Comments: _____

HEAD	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Ringing/Buzzing ears ☐ Decreased ROM ☐ Dizziness ☐ Increased Sensitivity ☐ Inflammation ☐ Sensitivity to Bright Light ☐ shallow Breathing
Radiates to	☐ Ears ☐ Eyes ☐ Face ☐ Left Ear ☐ Left Eye ☐ Left Jaw ☐ Neck ☐ Right Ear ☐ Right Eye ☐ Right Jaw ☐ Shoulder
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Afternoon ☐ During Night ☐ Evening ☐ Light Activities ☐ Moderate Activities
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bending ☐ Bright lights ☐ Chewing ☐ Closing mouth ☐ Deep Breathing ☐ Extension ☐ Grasping ☐ Housework ☐ Loud Noises ☐ Neck Movement ☐ Pushing

Comments: _____

JAW (TMJ)	
Location	☐ Left ☐ Right ☐ Both
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Clicking ☐ Popping ☐ Grinding ☐ Locking ☐ Tightness
Radiates to	☐ Head ☐ Neck ☐ Ears ☐ Face
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Standing
What makes it worse?	☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth

Comments: _____

NECK	
Location	☐ Right Front ☐ Left Front ☐ Right Back ☐ Left Back ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Stiffness ☐ Tightness ☐ ROM
Radiates to	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Both sides of head ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right shoulder ☐ Left shoulder ☐ Right arm ☐ Left arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Light Activities ☐ Moderate Activities
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Neck Movement ☐ Sneezing ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

Comments: _____

SHOULDER	
Location	☐ Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Both sides
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Weakness ☐ Decreased ROM
Radiates to	☐ Neck ☐ Right Shoulder blade ☐ Left Shoulder blade ☐ Trapezius muscle ☐ Right upper arm ☐ Left upper arm ☐ Right Elbow ☐ Left Elbow ☐ Right Forearm ☐ Left Forearm ☐ Right Wrist ☐ Left Wrist ☐ Right Hand ☐ Left Hand ☐ Right fingers ☐ Left fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Driving ☐ Housework ☐ Lifting ☐ Pulling ☐ Pushing ☐ Range of Motion ☐ Working

Comments: _____

ARM	
Location	☐ Right Arm ☐ Left Arm ☐ Both Arms
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Bruises/Abrasions ☐ Tingling ☐ Increased sensitivity ☐ Weakness
Radiates to	☐ Right Shoulder ☐ Left Shoulder ☐ Right Elbow ☐ Left Elbow ☐ Right Forearm ☐ Left Forearm ☐ Right Hand ☐ Left Hand ☐ Right Fingers ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Left Fingers ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Afternoon ☐ Evening ☐ Light Activities ☐ Moderate Activities ☐ Morning
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Housework ☐ Lifting ☐ Driving ☐ Working

Comments: _____

ELBOW	
Location	☐ Right Elbow ☐ Left Elbow ☐ Both Elbows
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Bruises ☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Weakness ☐ Decreased ROM
Radiates to	☐ Right Upper arm ☐ Left Upper arm ☐ Right Forearm ☐ Left Forearm ☐ Right Wrist ☐ Left Wrist ☐ Right Hand ☐ Left Hand ☐ Right Fingers ☐ Left Fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Light Activities ☐ Moderate Activities
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Flexion ☐ Extension ☐ Pronation/Supination ☐ Housework ☐ Lifting ☐ Driving ☐ Working

Comments:_____

FOREARM	
Location	☐ Right Forearm ☐ Left Forearm ☐ Both Forearms
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Bruises ☐ Tingling ☐ Increased sensitivity ☐ Weakness ☐ Burns ☐ Abrasions
Radiates to	☐ Right Upper arm ☐ Left Upper arm ☐ Right Elbow ☐ Left Elbow ☐ Right Wrist ☐ Left Wrist ☐ Right Hand ☐ Left Hand ☐ Right Fingers ☐ Left Fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Grasping ☐ Housework ☐ Lifting ☐ Driving ☐ Working

Comments:_____

WRIST	
Location	☐ Right Wrist ☐ Left Wrist ☐ Both Wrists
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Swelling ☐ Tingling ☐ Increased sensitivity ☐ Weakness ☐ Stiffness ☐ ROM
Radiates to	☐ Right Elbow ☐ Left Elbow ☐ Right Forearm ☐ Left Forearm ☐ Right Hand ☐ Left Hand ☐ Right Fingers ☐ Left Fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Driving ☐ Extension ☐ External Rotation ☐ Flexion ☐ Grasping ☐ Housework ☐ Internal rotation ☐ Lifting ☐ Writing

Comments:_____

HANDS AND FINGERS	
Location	☐ Right Hand ☐ Left Hand ☐ Both Hands ☐ Right Fingers ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Left Fingers ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Swelling ☐ Tingling ☐ Stiffness ☐ ROM
Radiates to	☐ Right Forearm ☐ Left Forearm ☐ Right Wrist ☐ Left Wrist
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Housework ☐ Lifting ☐ Driving ☐ Working ☐ Grasping ☐ Writing

Comments: _____

CHEST	
Location	☐ Left Chest ☐ Right Chest ☐ Both sides of chest
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Shallow breathing
Radiates to	☐ Right Ribs ☐ Left Ribs ☐ Right Upper back ☐ Left Upper back ☐ Right Lower back ☐ Left Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Deep breathing ☐ Upper body movement ☐ Coughing ☐ Sneezing ☐ Palpation

Comments: _____

RIBS	
Location	☐ Right Collar bone ☐ Left Collar bone ☐ Right Pectoral ☐ Left Pectoral ☐ Right Sternum ☐ Left Sternum ☐ Right Ribs ☐ Left Ribs
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Shallow breathing ☐ Soreness
Radiates to	☐ Right Upper back ☐ Left Upper back ☐ Right Chest ☐ Left Chest ☐ Right Shoulder ☐ Left Shoulder ☐ Right Arm ☐ Left Arm ☐ Right Lower back ☐ Left Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Deep breathing ☐ Upper body movement ☐ Lifting ☐ Working ☐ Palpation ☐ Housework

Comments: _____

UPPER BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Neck ☐ Right Ribs ☐ Left Ribs ☐ Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Upper body movement ☐ Lifting ☐ Working ☐ Sneezing ☐ Housework ☐ Coughing ☐ Bending Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

MID BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ Decreased ROM
Radiates to	☐ Neck ☐ Right Ribs ☐ Left Ribs ☐ Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ During Night ☐ Light Activities ☐ Moderate Activity
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Upper body movement ☐ Lifting ☐ Working ☐ Sneezing ☐ Housework ☐ Coughing ☐ Bending Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

LOWER BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Right Upper back ☐ Left Upper back ☐ Right Buttock ☐ Left Buttock ☐ Both Buttocks ☐ Right Hip ☐ Left Hip ☐ Right Thigh ☐ Left Thigh ☐ Right Calf ☐ Left Calf ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Range of motion ☐ Lifting ☐ Bending ☐ Lying down ☐ Working ☐ Housework ☐ Coughing. ☐ Sneezing Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

ABDOMEN	
Location	
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Rigidity ☐ Paresthesia ☐ Bruises ☐ Skin changes ☐ Vomiting
Radiates to	☐ Right Chest ☐ Left Chest ☐ Right Lower back ☐ Left Lower back ☐ Right Groin ☐ Left Groin ☐ Right Thigh ☐ Left Thigh
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Palpation ☐ Bending ☐ Lifting ☐ Walking

Comments:

HIP	
Location	☐ Right Hip ☐ Left Hip ☐ Both Hips
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Left Lower back ☐ Right Lower back ☐ Left Buttocks ☐ Right Buttocks ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Lifting ☐ Bending ☐ Straining ☐ Walking Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments:

BUTTOCKS	
Location	☐ Right Buttock ☐ Left Buttock ☐ Both Buttocks
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Decreased ROM ☐ Increased Sensitivity ☐ Loss of Balance ☐ Soreness
Radiates to	☐ Left Lower back ☐ Right Lower back ☐ Right Mid-back ☐ Left Mid-back ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Thigh ☐ Left Thigh
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bending ☐ Extension ☐ Flexion ☐ Lying Down ☐ Walking Downstairs ☐ Walking Upstairs Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments:

GROIN	
Location	☐ Left Groin ☐ Right Groin ☐ Both Groins
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Left Lower back ☐ Right Lower back ☐ Right Buttocks ☐ Left Buttocks ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Lifting ☐ Bending ☐ Straining ☐ Walking Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments:_____

THIGH	
Location	☐ Left Thigh ☐ Right Thigh ☐ Both Thighs
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ Decreased ROM
Radiates to	☐ Left Lower back ☐ Right Lower back ☐ Right Buttocks ☐ Left Buttocks ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Lifting ☐ Bending ☐ Straining Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments:_____

KNEE	
Location	☐ Left Knee ☐ Right Knee ☐ Both Knees
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Pain ☐ Inflammation ☐ Bruising ☐ Swelling
Radiates to	☐ Left Ankle ☐ Right Ankle ☐ Right Buttocks ☐ Left Buttocks ☐ Right Foot ☐ Left Foot ☐ Right Calf ☐ Left Calf
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Twisting R L ☐ Walking up or downstairs ☐ Weight bearing Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments:_____

CALF	
Location	☐ Left Calf ☐ Right Calf ☐ Both Calves
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Burning ☐ Decreased ROM ☐ Increased Sensitivity ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Weakness
Radiates to	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Ankle ☐ Left Ankle ☐ Left Foot ☐ Right Foot
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	Prolonged: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Weight bearing

Comments: _____

ANKLE	
Location	☐ Left ☐ Right ☐ Both
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Decreased ROM ☐ Increased Sensitivity ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Tingling ☐ Weakness
Radiates to	☐ Right Calf ☐ Left Calf ☐ Left Foot ☐ Right Foot ☐ Right Toes ☐ Left Toes
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Range of Motion ☐ Sitting ☐ Standing ☐ Stretching
What makes it worse?	☐ Range of motion ☐ Walking upstairs ☐ Walking downstairs ☐ Weight bearing Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

FOOT/TOES	
Location	☐ Left ☐ Right ☐ Both ☐ Toes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Decreased ROM ☐ Increased sensitivity ☐ Numbness ☐ Swelling ☐ Tingling
Radiates to	☐ Right Ankle ☐ Left Ankle ☐ Right Calf ☐ Left Calf ☐ Right Knee ☐ Left Knee ☐ Right Thigh ☐ Left Thigh ☐ Lower Back ☐ Left Lower Back ☐ Right Lower Back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Sitting ☐ Standing ☐ Stretching ☐ Decreased ROM
What makes it worse?	Prolonged: ☐ Sitting ☐ Standing ☐ Walking ☐ Movement ☐ Weight bearing ☐ Working

Comments: _____

OTHER COMPLAINTS:

☐ Balance loss ☐ Fatigue ☐ Irritability ☐ Memory loss ☐ Nervousness ☐ Tension ☐ Shortness of breath

_____
Patient's Signature

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box. If an activity does not cause pain or if pain does not affect an activity, leave box blank.

- **[1]** This activity **causes slight pain**, but I can do it.
- **[2]** This activity **causes mild pain**, but I can do it.
- **[3]** This activity **causes me moderate pain** & I can do it **<10 minutes**.
- **[4]** This activity **causes me moderate pain** & I can do it **<5 minutes**.
- **[5]** This activity **causes me severe pain** & I can do it **<10 minutes**.
- **[6]** This activity **causes me severe pain** & I can do it for **< 5 minutes**.
- **[7]** I **cannot perform** this activity due to pain and disability.

Self Care and Personal Hygiene:

	Bathing/ Showering		Washing Dishes
	Brushing teeth		Going to bathroom
	Putting on shoes		Washing face
	Eating		Putting on shirt
	Doing Laundry		Cooking
	Grooming hair		Taking out the trash
	Making the bed		Vacuuming
	Putting on pants		Sweeping

Physical Activities:

	Standing		Sitting
	Reclining		Walking
	Squatting		Kneeling
	Stooping		Bending forward
	Bending backward		Reaching overhead
	Reaching forward		Looking over your shoulder
	Throwing		Bending to the side

Functional Activities:

	Carrying small objects		Carrying gallon of milk
	Carrying large objects		Carrying bag/purse
	Mowing lawn		Cleaning windows
	Lifting weights off table		Exercising upper body
	Exercising lower body		Lifting object off floor
	Shoveling snow		Cleaning curtains
	Climbing stairs		Raking leaves
	Weeding		Pushing or pulling

Social and Recreational Activities:

	Bowling		Biking
	Jogging		Walking
	Hunting/ fishing		Knitting/ crocheting
	Swimming		Competitive sports
	Playing cards		Golfing
	Gardening		Dancing
	Yoga		Sewing
	Weeding		Other:

Difficulties with Traveling:

	Getting into/out of car		Driving in car for short periods of time
	Driving for long periods of time		Riding as passenger for short periods of time
	Riding as passenger for long periods of time		Riding in an airplane
	Riding on a bus		Exercising upper body
	Exercising lower body		

Other activities:

Use this scale for the following activities:

- **[1]** This activity is **slightly** affected by my condition.
- **[2]** This activity is **mildly** affected by my condition.
- **[3]** This activity is **moderately** affected by my condition.
- **[4]** This activity is **severely** affected by my condition.
- **[5]** I **cannot perform** this activity due to my condition.

	Concentrating		Reading
	Studying		Writing
	Using computer		Sleeping
	Looking down at cell phone		Coughing
	Sneezing		Sexual relations

Patient Name: _____ **DOB:** _____ **Doctor Signature:** _____ **Date:** _____

Insurance Coverage Information

Medical Insurance:

Insurance Carrier: _____ Phone: _____

Policy Holder name: _____ Policy Number: _____

Group Number: _____

Workers Compensation Injury:

Employer: _____ Work Number: _____

Address: _____ Supervisor: _____

Was injury/accident reported to supervisor? Y / N Date: _____ Time: _____

Workers Comp Carrier: _____ Policy #: _____

Carriers Phone: _____ Adjuster: _____

Claim Number: _____

Auto / Personal Injury:

Do you have "Med Pay" on your Auto Policy: Yes / No Amount: $ _____

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim Number: _____

Third Party Payer (other involved vehicle insurance)

Third Party (Person at Fault's) Name: _____ Ph: _____

THEIR Insurance Carrier: _____ Ph: _____

Address: _____

Adjuster: _____ Claim Number: _____

Patient Name: _____ **Date:** _____

Benttree Clinic

Patient Name:_____ **Insurance** _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Benttree Clinic for all benefits which maybe due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Benttree Clinic.

Furthermore, I hereby irrevocably assign to Benttree Clinic the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Benttree Clinic.

Authorization to Release Medical Record Information:

Benttree Clinic is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Benttree Clinic. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Benttree Clinic.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of patient or responsible party_____

Witness _____

Benttree Clinic

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

Benttree Clinic

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

   You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print)

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

TO BETTER SERVE YOU, PLEASE PROVIDE US WITH THE INFORMATION NEEDED

I give Benttree Clinic, 13153 N. Dale Mabry Hwy, Unit 109, Tampa, Florida 33618 and it's representatives permission to communicate to me via the contact information below;

Name: _____

Email Address:_____

Cell Phone Texting:_____

Today's Date:_____