OneCare Spine & Injury Centers ❑ **Daytona Beach** ❑ **Palm Coast**

Last Name: _____First Name: _____Middle Int: _____

If Patient is a Minor (under age of 18): Provide Parent/Guardian Name: _____

Do you have a nickname you prefer? _____

Birthdate: _____/_____/_____ ❑ Male ❑ Female

Home Address: _____ City _____ State: ____ Zip: _____

Mobile Phone: (_____) _____ Alt. Phone: (_____) _____

Email: _____

May the office send you appointment reminders by email? ❑ Yes ❑ No

EMERGENCY INFORMATION

Name you wish on file: _____ Phone: (_____) _____-_____

REASON FOR TODAY'S VISIT

The reason for this visit is: ❑ Auto Accident ❑ Motorcycle Accident ❑ Fall

❑ Sports injury ❑ Work Injury ❑ Wellness Visit ❑ Independent Medical Exam

❑ Other reason: _____

❑ What Date did the Accident or Injury occur: _____/_____/_____

MEDICATION

Medications currently taking or have a prescription for:

1. _____for _____ Prescribed by? _____
2. _____for _____ Prescribed by? _____
3. _____for _____ Prescribed by? _____
4. _____for _____ Prescribed by? _____
5. _____for _____ Prescribed by? _____

Please Check if you are currently experiencing: Now or Had Prior

Condition	Now	Had Prior	Condition	Now	Had Prior	Condition	Now	Had Prior
Stroke			Heart Disease / Murmur			Arteriosclerosis		
Diabetes			Heart Attack prolapse			High Blood Pressure		
Arthritis			Dizziness/Vertigo			Cancer		
Numbness			Fainting Spells			Migraines		
Anemia			Asthma			Emphysema		
Mitral Valve			Glaucoma			Goiter		
Gout			Osteoporosis / Osteopenia			Alcoholism		
Hepatitis			Allergies			Lupus		
Malaria			Measles			Depression		
Anxiety			Multiple Sclerosis			Mumps		
COPD			Crohn's Disease			Parkinson's		
Polio			Pins & Needles Feeling			Rheumatic fever		
Scarlet fever			Shingles			Aids/HIV		
Tuberculosis			Typhoid fever			Ulcer(s)		
Fever/Chills			Night pain waking you up			Loss of bladder control		
Infections			Unexplained Weight Loss			Seizures or Fainting Spells		

Please sign: _____Print: _____ Date: _____

OneCare Spine & Injury Centers ❑ **Daytona Beach** ❑ **Palm Coast**

SURGERY:

❑ **I've never had any surgery**

Put **YEAR** of surgery next to those checked:

❑ Tonsils:	❑ Heart:	❑ Shoulder:	❑ Hip:	❑ Eye:
❑ Appendix:	❑ Stent(s):	❑ Elbow:	❑ Knee:	❑ Ear:
❑ Gallbladder:	❑ Carotid Artery:	❑ Wrist:	❑ Ankle:	❑ Prostate:
❑ Intestines:	❑ Varicose Veins:	❑ Hand:	❑ Foot:	❑ Serious Illness:
❑ Kidney:	❑ C-Section:	❑ Dislocations:	❑ Cosmetic:	
❑ Spine:	❑ Hysterectomy:	❑	❑ Fractures:	

ALLERGIES

❑ To Environment: ❑ Dust ❑ Pollen ❑ Pets ❑ Mold/Mildew ❑ Other: _____

❑ I am allergic to Latex

❑ To Medications: _____

Reactions: ❑ Sneezing ❑ Hives ❑ Itching ❑ Rash ❑ Swelling ❑ Other: _____

FAMILY HISTORY

Relative	Age (if living)	Age (if passed)	Known Health Conditions they had or currently suffer from
Mother			
Father			

SOCIAL

Current Age: _____ **Are you**: ❑ Right handed ❑ Left handed ❑ Ambidextrous

Status:

❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Number of Children: _____

Tobacco:

❑ I do not smoke or chew tobacco products

❑ Quit Cigarettes (Did you replace with something else? _____)

❑ Cigarettes (How many average per day? _____)

❑ Vape

❑ Smokeless Chew

❑ Cigars (How often: _____)

Alcohol:

❑ I do not drink alcoholic beverages

❑ Rare/socially

❑ Daily

❑ History of Treatment for Addiction

Exercise:

❑ No specific exercise routine outside of normal work or daily activity

❑ I exercise at home or at the gym. How many Days Per Week on average?

❑ 1-2 ❑ 3-4 ❑ 5-7

❑ I am exercising less or none right now due to my current injuries

EMPLOYMENT INFORMATION

If not currently employed, are you: ❑ Student ❑ A stay at home caretaker ❑ Retired ❑ In-between jobs

Employer/School: _____Occupation: _____ ❑ Full ❑ Part Time

Employer/School: _____Occupation: _____ ❑ Full ❑ Part Time

Job Duties: _____

Did you miss any time from work or classes?

❑ No, I have not missed any time **OR** ❑ I have missed _____ Days _____ Weeks _____ Months

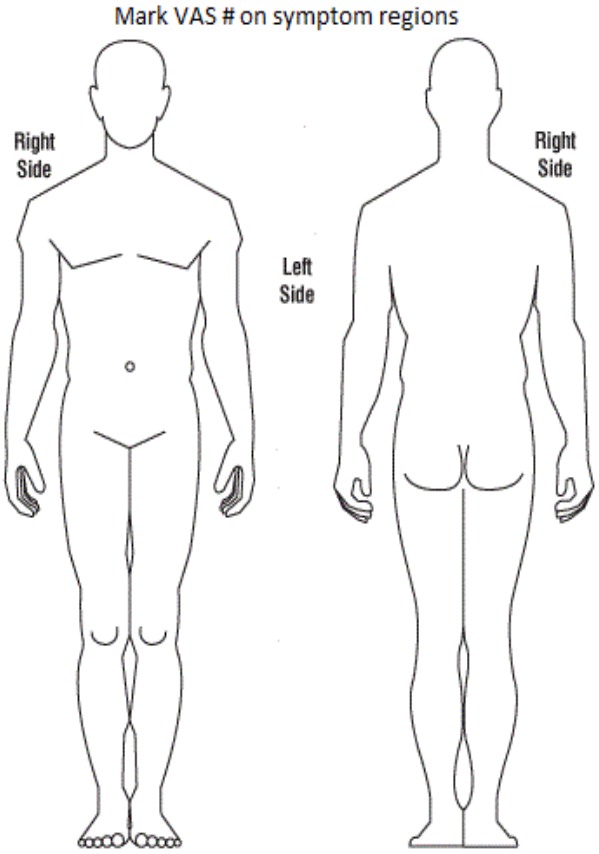
Any Light Duty Available? ❑ No ❑ Yes. If you have returned to work, are you on light duty right now? ❑ Yes ❑ No

Please sign: _____Print: _____ Date: _____

OneCare Spine & Injury Centers ❑ **Daytona Beach** ❑ **Palm Coast**

PAIN / SYMPTOM LOCATIONS:

Please mark pain areas on the body diagrams:



Please sign: _____Print: _____ Date: _____ NP3/3

When Finished, please return to Front Desk. Thank You!

Doctors Notes: