

Eplett Chiropractic Life Center

DR. JOSEPH EPLETT, D.C., P.A.
429 Fifth Avenue, Indialantic, FL 32903
321-733-4434

WELCOME TO OUR OFFICE!

Date: _____

Name: _____ SS#: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Ph: _____ cell: _____ Work Ph: _____

Occupation: _____ Employer: _____

Address: _____

Marital Status: _____ Spouse Name: _____

Are you, or is there a possibility you are pregnant? YES NO

Referred by: _____ E-mail Address: _____

Insurance: Medicare Auto accident Workers' Compensation Liability

Name of Company _____ Phone # _____

Is there any possibility of legal action in your case? YES NO

Please check any that apply:

Pain in: Head Neck Shoulder Mid-back Arms Hands
 Hips Chest Legs Abdomen Low-back Feet Knees

Are you bothered by: Stress Nervousness Indigestion Cramps
Arthritis
 Weakness Sleeplessness Constipation Nausea
 Dizziness Numbness Stomach trouble Lung trouble
 Paralysis Cancer
 Stiffness Bladder trouble Poor circulation Sinusitis
Diabetes
 Deafness Kidney trouble Depression Fatigue
Asthma
 Blindness Heart trouble High Blood Pressure

Major complaints: _____

Previous injuries (Mo/Yr): _____

Previous surgeries (Mo/Yr): _____

Do you take medication (prescription/over the counter) Which ones and why? _____

Does your present condition interfere with normal living or work? Yes No

Have you ever had Chiropractic care before? _____ If yes, when? _____

Chiropractor: _____ Were x-rays taken by that chiropractor? Yes No

Do you want: Temporary relief Lasting correction

I AUTHORIZE DR. JOSEPH G. EPLETT TO TREAT ME AS DETERMINED NECESSARY BY EXAM. I UNDERSTAND ALL INCURRED EXPENSES ARE MY RESPONSIBILITY, REGARDLESS OF MY CHOICE OF PAYMENT.

I further understand that my active participation is a requirement for treatment by Dr. Eplett and to that end I will attend the FREE Doctors report where Dr. Eplett will show me the x-rays and explain his treatment and plans for my care.

Patient Signature: _____