

# TOTAL HEALTH OF WESLEY CHAPEL

20433 Bruce B. Downs Blvd  
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Chiropractic Physician

## PATIENT INFORMATION:

(Please Print)

Date \_\_\_\_\_ 200\_\_

Name \_\_\_\_\_  
First Middle Initial Last

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

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

Female  Male DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Whom may we thank for referring you to us? \_\_\_\_\_  
(Please check one)

Minor  Married  Divorced  Widowed  Single  Separated

## SYMPTOMS:

Are you:  Right-handed  Left-handed  Ambidextrous

Describe your symptoms \_\_\_\_\_

How often?  Constantly (76-100%)  Frequently (51-75%)  Occasionally  
(26-50%)  Intermittently (0-25%)

When did you first notice the symptoms (or date of accident)? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_ Where  
specifically is the problem located? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

What describes the nature of your symptoms?

Sharp  Shooting  Dull ache  Burning  Numb  Tingling  Other \_\_\_\_\_

How are your symptoms changing?  Getting better  Not changing  Getting Worse

Whom have you seen for your symptoms?

No one  Other chiropractor \_\_\_\_\_  Medical Doctor  Other \_\_\_\_\_

What treatment and/or test did you receive and when?

X-rays /CT Scan/ MRI/ Other: \_\_\_\_\_

Medication (circle) Aspirin Tylenol Ibuprofen Other \_\_\_\_\_

Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Laying down  Rising

Other: \_\_\_\_\_

Rate the severity of your pain (1 mild pain or discomfort to 10 severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? \_\_\_\_\_

**HEALTH HISTORY:** (check only those conditions which are applicable)

- |   |                                     |   |   |  |
|---|-------------------------------------|---|---|--|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures  | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Tumors, Growths   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Polio              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Other _____        |                                     |   |   |  |

Previous Surgeries and Dates: \_\_\_\_\_

Dates of last exams \_\_\_\_\_ (Women) Date of last menstrual cycle: \_\_\_\_\_

Please list ALL medications you are currently taking:  
Blood Pressure \_\_\_\_\_

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

Diabetes \_\_\_\_\_

Other \_\_\_\_\_

(Please use back of sheet for additional space)

**DAILY HABITS:**

What type of exercise do you perform on a daily basis?  None  Moderate  Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) \_\_\_\_\_

What vitamins do you currently take? \_\_\_\_\_

What other nutritional supplements do you take (if any)? \_\_\_\_\_

Do you smoke?  Yes  No How much per day? \_\_\_\_\_ How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

**Receipt of Notice of HIPPA Privacy Practices Written Acknowledgement form**

I have been given a copy, and/or been asked by the staff of Total Health of Wesley Chapel to read a copy of their Notice of HIPPA Patient Privacy Practices and as it pertains to Total Health of Wesley Chapel.

\_\_\_\_\_  
**Signature of Patient or Parent  
Or Legal Guardian**

\_\_\_\_\_  
**Date**

**AUTHORIZATION:**

I certify that the information provided is accurate to the best of my knowledge. I further understand that giving incorrect information can be dangerous to my health. I authorize this office to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company pay directly to TOTAL HEALTH OF WESLEY CHAPEL, INC.; I further understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X \_\_\_\_\_  
**SIGNATURE OF PATIENT (or parent if a minor child)**

\_\_\_\_\_  
**DATE**