Mark E. Jeter, D.C.
615 Cape Coral Pkwy W #105
Cape Coral, Florida 33914
(239) 549-2225
drmarkjeter.com

Jeter CHIROPRACTIC HEALTH CENTERS

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When? _____ If so, whom? _____

Whom may we thank for referring you?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code

Home Phone | Spouse's Name

Email Address

Cell Phone | Child's Name and Age

Emergency Contact

Phone | Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City | State/Province | ZIP/Postal Code

Work Phone

Insurance Carrier | Policy Number

Primary Care Provider's Name

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. **The symptom(s) that have prompted me to seek care today include:** _____

_____

Patient name _____

2. **And are the result of (darken circle):** ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

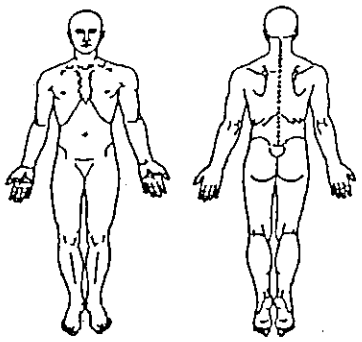
3. **Onset** (When did you first notice your current symptoms?)
_____

4. **Intensity** (How extreme are your current symptoms?)
0 ○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? _____
_____

6. **Quality of symptoms** (What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other _____

7. **Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. **Prior Interventions** (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other _____
○ Physical therapy ○ Massage _____

11. **What else should Dr. Jeter know about your current condition?** _____
_____

12. **How does your current condition interfere with your:**
Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

	Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
a. Musculoskeletal																NONE ○
	○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○ ○ Hip disorders
	○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○ ○ Poor posture
																Initials ____
b. Neurological																NONE ○
	○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○ ○ Numbness
																Initials ____
c. Cardiovascular																NONE ○
	○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○ ○ Excessive bruising
																Initials ____
d. Respiratory																NONE ○
	○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○ ○ Pneumonia
																Initials ____
e. Digestive																NONE ○
	○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○ ○ Diarrhea
																Initials ____
f. Sensory																NONE ○
	○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○ ○ Loss of taste
																Initials ____
g. Integumentary																NONE ○
	○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○ ○ Rash
																Initials ____

Consultation Notes

_____
Doctor's Initials

Jeter Chiropractic Health Cntr
Mark E. Jeter, D.C.

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	
○	○	Alcoholism	○	○	Tuberculosis
○	○	Allergies	○	○	Typhoid fever
○	○	Arteriosclerosis	○	○	Ulcer ____
○	○	Cancer			Other: ____
○	○	Chicken pox			____
○	○	Diabetes			____
○	○	Epilepsy			____
○	○	Glaucoma			____
○	○	Goiter			____
○	○	Gout			____
○	○	Heart disease			____
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ____
- ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____
- ____
- ____
- ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____

____

____

○ ○ Medications (prescription and over-the-counter):

____

____

____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Jeter about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

19. Are there any other hereditary health issues that you know about? ____

____

20. Social History

Tell Dr. Jeter about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____

Hobbies: ____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials

Jeter Chiropractic Health Cntr
Mark E. Jeter, D.C.

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____ **23. How much sleep do you average per night?** _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ **25. What is your preferred sleeping position?** _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials ____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials ____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials ____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Patient name

Consultation Notes

Doctor's Initials

Jeter Chiropractic Health Cntr
Mark E. Jeter, D.C.

Jeter CHIROPRACTIC HEALTH CENTERS

Informed Consent Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic/medical procedures, including various modes of physical therapy and diagnostic x-rays by Mark E. Jeter, D.C.. This consent is also extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or are associated with this office.

I certify that I will have the opportunity to discuss, with Mark E. Jeter, D.C. and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and understand, that as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Patient's name (*please print*)

_____
Patient's signature

_____
Date

_____
Patient's representative (*If patient is a minor or physically/mentally impaired*)

_____
Representative's relationship to patient

_____
Witness's name (*please print*)

_____
Witness's signature

_____
Date

_____
Translated by

r Mark E. Jeter, D.C

Jeter CHIROPRACTIC HEALTH CENTERS

ASSIGNMENT OF BENEFITS

I, _____ authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits to the party who accepts assignment of benefits listed below.

_____ _____

Signature of patient Date

I authorize payment of medical benefits to the physician or supplier listed below for the serviced submitted to my insurance company on my behalf on all present and future HCFA 1500 forms.

_____ _____

Signature of patient Date

Physician receiving benefits:

Mark E. Jeter D. C.
615 Cape Coral Pkwy W. STE 105
Cape Coral, FL 33914
License #: CH0006411
Tax ID #: 65-0991745