DIXON CHIROPRACTIC
AKA: Head to Toe Posture & Rehab Center, LLC
10063 Cleary Blvd. Plantation, FL 33324
Dr. Ashley Dixon, DC Phone: 954-372-7795 Fax: 866-372-7795

Today's Date: _____ D.O.I:_____

Initial Information

Name: _____ DOB: _____ Age:_____ Sex: ☐Male ☐Female

Address:_____

Phone:_____ Email:_____

Do you mind if we contact you by email for updates and events? ☐Yes, sure. ☐Maybe some other time.

Emergency Contact: Name:_____ Phone:_____ Relation:_____

Main Complaints

What are your complaints?

_____

Are there any activities difficult to perform?

_____

Check any of the following conditions you have had:

☐AIDS/HIV	☐Diabetes	☐High Cholesterol	☐Rheumatoid Arthritis
☐Allergies	☐Digestion problems	☐Insomnia	☐Sciatica
☐Anemia	☐Earache	☐Irregular cycle	☐Seizure/Epilepsy
☐Arm/shoulder pain	☐Ear ringing	☐Kidney problems	☐Shingles
☐Arthritis	☐Epilepsy	☐Leg pain	☐Sinus problems
☐Asthma	☐Headaches/Migraines	☐Low back pain	☐Stroke
☐Bladder problems	☐Heart Attack/Stroke	☐Neck pain	☐Thyroid problems
☐Breathing problems/COPD	☐Hemorrhoids	☐Neuropathy	☐TMJ
☐Cancer _____	☐Herniated Disks	☐Poor circulation	☐STD_____
☐Chronic fatigue	☐Hepatitis _____	☐Prostate problems	☐Vertigo/Dizziness
☐Deafness	☐High Blood Pressure	☐Psychiatric problems	☐Other:_____

List any surgeries:_____

List any previous broken bones:_____

List any allergies:_____

Doctor:Dr. Ashley Dixon, DC_____ Date:_____

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FOR FEMALES ONLY:

In order for us to fully evaluate you, we may be required to take x-rays of some parts of your body. It has been predicted that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure that accidentally, knowingly, or otherwise, no Fetus (unborn child) be exposed to radiation from x-ray machines, we ask you to provide us with the following information. We thank you for the information. This information is strictly confidential and is solely used for the purpose it is intended.

Is there a chance that you may be pregnant? NO YES MAYBE

Have you ever been in a car accident? When?_____

Have you ever had a slip & fall or other injury? When?_____

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I authorize Head to Toe Posture & Rehabilitation Center, LLC DBA Dixon Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for serves provided. I certify that the above information is true to the best of my knowledge .

_____ _____ _____
Signature Date Parent (if patient is a minor)

Doctor:_____ Dr. Ashley Dixon, DC Date:_____