340.227.6409
studio@serafina.love

5221 Curacao Gade
suite 206, St Thomas VI

PERSONAL INFORMATION

Name _____ Gender ❑ M ❑ F
*If Female, are you pregnant? ❑ No ❑ Yes
Today's Date _____ Birthdate _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Email Address _____
What is your occupation? _____ Employer:_____
Have you seen a chiropractor before? ❑ No ❑ Yes, Who? (most recent)_____
Emergency Contact Name _____ Relationship_____
Emergency Contact Phone Number _____
Social Security Number _____-_____-_____ Marital Status _____
Are you ❑ Military ❑ Veteran ❑ Military/Veteran Spouse ❑ N/A
How did you hear about us? ❑ Facebook ❑ Google Search ❑ Referred by_____ ❑ Other _____

OFFICE VISIT REASON

CHIEF COMPLAINT

1. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
How did this begin? _____
How often do you feel it? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally ❑ Daily ❑ Weekly
What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling
Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

- **Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving ❑ Bending ❑ Lifting ❑ Other:_____**
- **How long can you do above before you are in pain or restricted? _____ sec / min / hour**
- Does it radiate anywhere? ❑ No ❑ Yes (where?): _____
- What makes it better? _____ ❑ Nothing
- What makes it worse?_____ ❑ Nothing
- Have you had this issue treated before? ❑ No ❑ Yes
  - If Yes, What type of treatments?_____Result? ❑ Same ❑ Better ❑ Worse ❑Other_____

OTHER COMPLAINTS

2. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
How did this begin? _____
How often do you feel it? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally ❑ Daily ❑ Weekly
What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling
Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

- **Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving ❑ Bending ❑ Lifting ❑ Other:_____**
- **How long can you do above before you are in pain or restricted? _____ sec / min / hour**
- Does it radiate anywhere? ❑ No ❑ Yes (where?): _____
- What makes it better? _____ ❑ Nothing
- What makes it worse?_____ ❑ Nothing
- Have you had this issue treated before? ❑ No ❑ Yes
  - If Yes, What type of treatments?_____Result? ❑ Same ❑ Better ❑ Worse ❑Other_____

3. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
How did this begin? _____
How often do you feel it? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally ❑ Daily ❑ Weekly
What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling
Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

- **Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving ❑ Bending ❑ Lifting ❑ Other:_____**
- **How long can you do above before you are in pain or restricted? _____ sec / min / hour**
- Does it radiate anywhere? ❑ No ❑ Yes (where?): _____
- What makes it better? _____ ❑ Nothing
- What makes it worse?_____ ❑ Nothing
- Have you had this issue treated before? ❑ No ❑ Yes
  - If Yes, What type of treatments?_____Result? ❑ Same ❑ Better ❑ Worse ❑Other_____

REVIEW OF SYSTEMS

OTHER THAN WHAT YOU'VE ALREADY DESCRIBED, DO YOU HAVE ANY ADDITIONAL HEALTH CONCERNS ?

❑ Muscle, Bones, Joints: _____

❑ Nerves, Headaches, Dizziness, Emotional: _____

❑ Head, Eyes, Ear, Nose, Throat: _____

❑ Heart, Blood Pressure, Circulation:_____

❑ Shortness of Breath, Coughing, Athsma, or Lung Condition: _____

❑ Stomach, Bowels or Digestive Condition:_____

❑ Genital, Bladder, or Urinary Conditions :_____

❑ Diabetes, Thyroid, or Glandular Conditions:_____

❑ Skin or Bleeding Conditions: _____

❑ Medication Allergies: _____

HEALTH HISTORY

PERSONAL SURGICAL HISTORY

Have you had any surgeries? ❑ No ❑ Yes, Explain (Type and Year) _____

_____

PLEASE LIST CURRENT MEDICATIONS: _____

_____

PLEASE LIST ANY ILLNESSES (type & year): _____

_____

PLEASE LIST ANY ACCIDENTS (describe & approx date): _____

_____

FAMILY HISTORY

Are there any relevant diseases in your immediate family such as cancers or heart conditions? ❑ No ❑ Yes,

Please describe _____

AUTO ACCIDENT : IF DUE TO A RECENT AUTO ACCIDENT

Date of accident? _____/_____/_____

Adjusters Name? _____

Adjusters phone # (if known) _____ Email Address _____

# of passengers _____

YOUR Auto Insurance Carrier? ? _____**YOUR** Claim #? _____

Were you seen at a medical facility since the accident occurred? ❑ Yes ❑ No

If yes, please provide name of facility you were seen at? _____

INSURANCE INFO

Insurance Payer: _____ Insurance Plan Name: _____

ID/Policy Number: _____ Group Number: _____

PLEASE TEXT FRONT AND BACK OF YOUR INSURANCE CARD TO OUR BILLING DEPARTMENT: 340.203-2642

HIPPA CONSENT

I agree to Serafina's Privacy Notice that has been provided to me.

❑ Yes I consent ❑ No I do not consent

MEDIA RELEASE

May we use photos or videos of you for our social media and community education?

❑ Yes ❑ No

By checking "YES" I undersatnd my consent is voluntary and I won't receive any compensation. I waive rights to approve final content and release Serafina from liabilities related to their use.

PATIENT SIGNATURE

Patient Signature _____ ***Date*** _____

*(I agree to pay a no call, no show fee of $75 if I don't show up. Reschedules are **always** welcome.)*