Steven Bowman, M.D.

Board Certified Internal Medicine
Wolstein Chiropractic & Sports Injury Center
32976 US Hwy 19 N. Plam Harbor, FL. 34684
P: 727-787-6677 F: 727-787-1177

A. Patient Information

Name: _____ D.O.B: _____
Today's Date: _____ Home/Cell Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
E-mail: _____
Sex: Male☐ Female☐ SS#: _____ ☐ Married☐ Widowed☐ Single☐ Divorced
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Preferred Language: _____ Ethnicity: _____
How did you hear about us? _____

B. Employer Information:

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____
Job Description: _____

C. Reason For Visit:

_____
_____

Have you seen a doctor for this condition? Yes: ____ No: ____
Doctor's Name: _____
Doctor's Address: _____
_____
Doctor's Phone: _____
Date Consulted: _____ Diagnosis: _____

Have you seen a doctor for this condition? Yes: ____ No: ____
Doctor's Name: _____
Doctor's Address: _____
_____
Doctor's Phone: _____
Date Consulted: _____ Diagnosis: _____

Height: _____ **Weight:** _____

Smoking Status:
Never _____ Former _____ Social _____ Some Days _____ Every Day _____

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D. Symptoms:

Approximately when did your symptoms start: _____

How did your symptoms start: _____
_____
_____

Describe your symptoms: _____
_____
_____

Are the symptoms getting worse: Yes ___ No ___ **Are symptoms:** Constant ___ Come & Go ___

Do symptoms interfere with: Work ____ Sleep ____ Daily Routine ____ Social Life ____

Please rate pain intensity over the past 4 weeks (circle):

1 2 3 4 5 6 7 8 9 10 Unbearable

How often do you experience symptoms:

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

E. Medical/Health History:

Please list any medications you are taking:

Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____

Please list any allergies: _____
_____
_____

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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AUTHORIZATION TO RELEASE RECORDS:

ATTENTION MEDICAL RECORDS DEPARTMENT

Physician: _____

Medical Facility: _____

Phone: _____

Fax: _____

Please release all records, radiology/diagnostic reports and any results pertaining to any and all treatment rendered to the following patient.

Patient Name: _____

DOB: _____ /_____ /_____

Social Security Number: _____ - _____ - _____

Thank You,

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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RELEASE/WAIVER FORM:

I accept full responsibility for my use of any and all apparatus, appliances, facility privileges, or service whatsoever owned by Wolstein Chiropractic & Sports Injury Center, it's shareholders, directors, employees, representatives or agents. I hold them harmless for any and all loss, claim, injury, damage or liability sustained or incurred by me resulting there from.

I fully understand and agree that I am engaging in physical exercise and the use of exercise equipment owned by Wolstein Chiropractic & Sports Injury Centers, and training & instruction, which could cause injury.

I am voluntarily participating in these activities and assume all risks that might result. I hereby agree to waive any claim or rights I might otherwise have to sue the facility, it's employees or agents for injury on account of these activities. I have carefully read this waiver/release and fully understand it is a release of liability.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____