Dr. Sheryl Haynes, D.O.

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: ____

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INITIAL VISIT

Patient Name: ________________ DOB: ____________ Gender: M ___ F ___
Date: ______________ Date of Injury: ______________

Blood Pressure: _____/_____ Pulse: __________ Height: _____'_____" Weight: __________

SESSION NOTES:

Continue Chiropractic Care: Y ____ N ____

Trigger Injection Point(s)
Location:
20550 ___ 20551 ___ 20553 ___ 20600 ___ 20605 ___ 20610 ___ 20612 ___

1% Lidocaine _____
Dexamethasone _____
Kenalog _____

Physician Signature: ______________________________ Date: _______________