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**PATIENT INFORMATION CARD**

DATE \_\_\_\_\_

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS.

1. Name - First _____ Last _____		2. Home Phone _____	Work Phone _____	Cell / Other _____
3. Complete address (Include city, state and zip) _____			Primary Language _____	E-Mail Address _____
6. <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	7. Emergency contact (Name & Phone Number): _____		Sex _____	Date of Birth _____
8. Occupation _____		Describe all complaints starting with the one that gives you the most pain.		
9. Employer name, address & phone # _____		1. _____		
10. How did the pain start? _____		2. _____		
When did the pain start? _____		3. _____		
		4. _____		
		5. _____		
		6. _____		
		7. _____		
		8. _____		
Description of Pain & area affected: <input type="checkbox"/> Continuous _____ <input type="checkbox"/> Sharp _____ <input type="checkbox"/> Dull _____ <input type="checkbox"/> Intermittent _____ <input type="checkbox"/> Burning _____ <input type="checkbox"/> Radiating _____ <input type="checkbox"/> Throbbing _____ <input type="checkbox"/> Numbness _____ <input type="checkbox"/> Tingling _____ <input type="checkbox"/> Positions, which aggravate pain _____				
Opinion of Symptoms: <input type="checkbox"/> Improving <input type="checkbox"/> Getting worse <input type="checkbox"/> The same				
11. Referred By _____		12. Have you ever had chiropractic care before? <input type="checkbox"/> No <input type="checkbox"/> Yes Where? _____		13. Social Security # _____
14. Are you on Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes Medicare # _____		15. Are you on Medicaid, (ADC), etc? <input type="checkbox"/> No <input type="checkbox"/> Yes Medicaid # _____		16. Are you on a reimbursing insurance policy? <input type="checkbox"/> No <input type="checkbox"/> Yes Company Name: _____
17. Please Indicate if you are here for care because of: <input type="checkbox"/> an on the job injury <input type="checkbox"/> an auto accident <input type="checkbox"/> a home injury				
Date injured _____	Insurance Company _____	Attorney's Name (if any) _____	Attorney's Address & Phone # _____	
18. Have you ever had falls, auto accidents, or injuries? <input type="checkbox"/> Yes. Please explain <input type="checkbox"/> No.	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY	
	_____	_____	_____	
	_____	_____	_____	
19. Have you ever had surgery? <input type="checkbox"/> Yes. Please explain <input type="checkbox"/> No.	MONTH, YEAR	TYPE OF SURGERY	COMMENTS	
	_____	_____	_____	
	_____	_____	_____	
20. Are you presently taking medications? <input type="checkbox"/> Yes. Please List <input type="checkbox"/> No.	NAME OF DRUG	DOSES PER DAY	LENGTH OF TIME TAKING	
	_____	_____	_____	
	_____	_____	_____	
21. For Women Only		1. Date of last menstruation: _____		
		2. Pregnancy test taken recently? <input type="checkbox"/> No. <input type="checkbox"/> Yes. Results of test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		

(PLEASE TURN OVER)

22. Please check any of the following that give you difficulty.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Fainting                           | <input type="checkbox"/> Heart attacks          | <input type="checkbox"/> Numbness                  |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Loss of balance                    | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Constipation              |
| <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Ringing in ears                    | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Kidney Trouble            |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Blurred vision                     | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Menstrual cramps and pain |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Light bothers eyes                 | <input type="checkbox"/> Stomach trouble        | <input type="checkbox"/> Menstrual irregularity    |
| <input type="checkbox"/> Hay fever              | <input type="checkbox"/> Neck pain                          | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Muscle spasms in neck              | <input type="checkbox"/> Inner tension          | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Grating in neck                    | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Sleeping problems         |
| <input type="checkbox"/> Tightness of throat    | <input type="checkbox"/> Tightness of shoulder muscles      | <input type="checkbox"/> Cold sweats            | <input type="checkbox"/> Painful joints            |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Pain in shoulders and arms         | <input type="checkbox"/> Gall bladder trouble   | <input type="checkbox"/> Pinched nerves in back    |
| <input type="checkbox"/> Thyroid trouble        | <input type="checkbox"/> Pins and needles in arms and hands | <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Pins and needles in legs  |
| <input type="checkbox"/> Twitching of face      | <input type="checkbox"/> Cold hands                         | <input type="checkbox"/> Intestinal gas         | <input type="checkbox"/> Swollen ankles            |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Chest pains                        | <input type="checkbox"/> Low back pain          | <input type="checkbox"/> Cold feet                 |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Shortness of breath                |   | <input type="checkbox"/> Pains in legs and feet    |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Chest pain                         |   |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Mid-back pain                      |   |  |

**DO NOT WRITE BELOW THIS LINE**

**Doctor's Use Only**

**Comments:**

**SPINAL ANALYSIS**

**PALPATION ANALYSIS**

**LT RT**

	SPINAL ANALYSIS	LT	RT
At			
Ax			
3C			
4			
5			
6			
7			
1D			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
1L			

**Work Restriction:**  Yes  No  
No work from \_\_\_\_\_ to \_\_\_\_\_

Cervical Support  Yes  No  
Lumbar Support  Yes  No  
Pregnant  Yes  No

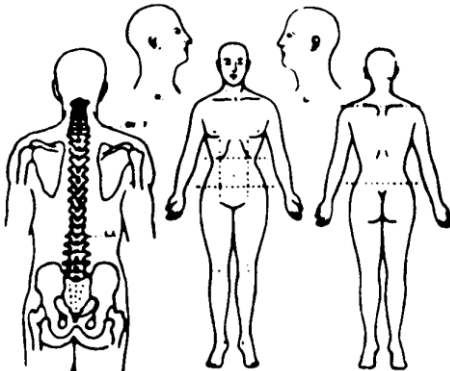
- |  |  |
|--|--|
| <input type="checkbox"/> Kemp Test _____         | <input type="checkbox"/> Cerv. Flexion ____          |
| <input type="checkbox"/> Hibbs test _____        | <input type="checkbox"/> Cerv extension ____         |
| <input type="checkbox"/> Bragard test _____      | <input type="checkbox"/> Cerv lat flexion (l) ____   |
| <input type="checkbox"/> Lasegue test _____      | <input type="checkbox"/> Cerv, Lat flexion (r) _____ |
| <input type="checkbox"/> Low extended extr _____ | <input type="checkbox"/> Cerv. Rotation (l) _____    |
| <input type="checkbox"/> Fabere Patrick _____    | <input type="checkbox"/> Cerv. Rotaton (r) _____     |
| <input type="checkbox"/> Valsalva test _____     | <input type="checkbox"/> For amina compression ____  |
| <input type="checkbox"/> Rhomberg test _____     | <input type="checkbox"/> Shoulder depressor _____    |

- |   |
|---|
| <input type="checkbox"/> Dt. Flexion ____           |
| <input type="checkbox"/> Dt. Extension ____         |
| <input type="checkbox"/> Dt. Lat. flexion (l) _____ |
| <input type="checkbox"/> Dt. Lat. flexion (r) _____ |
| <input type="checkbox"/> Dt. Rotation (l) _____     |
| <input type="checkbox"/> Dt. Rotation (r) _____     |

**Muscle Testing**

Upper extremities- Rt 012345 Lt 012345  
Lower extremities- Rt 012345 Lt 012345

George / Klein test = rt \_\_\_\_\_ lt \_\_\_\_\_  
Symptoms – headache \_\_\_\_\_ vomiting \_\_\_\_\_  
Nausea \_\_\_\_\_ dilated pupils \_\_\_\_\_  
Dizziness \_\_\_\_\_ nystamus \_\_\_\_\_



Circle area of complaint

2			
3			
4			
5			
SAC			
R ILI			
L ILI			
Coc			

CER \_\_\_\_\_  
F S \_\_\_\_\_  
PELVIC \_\_\_\_\_  
C.S. \_\_\_\_\_ L.S. \_\_\_\_\_

**Deerefield Leg Check**

Supine R \_\_\_\_\_ L \_\_\_\_\_  
Prone R \_\_\_\_\_ L \_\_\_\_\_