King Health Center
Dr. Gary G. King
7429 Conroy-Windermere Road
Orlando, FL 32835

Patient Information

Date: _____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____
E-Mail_____
Occupation_____
Employer_____
Employer Address_____
Employer Phone#_____
Spouse's Name_____

Payment for services will be: ☐ Cash ☐ Check ☐ Credit Card

Phone Numbers

Home_____
Cell_____
Work_____
Best time and place to reach you_____

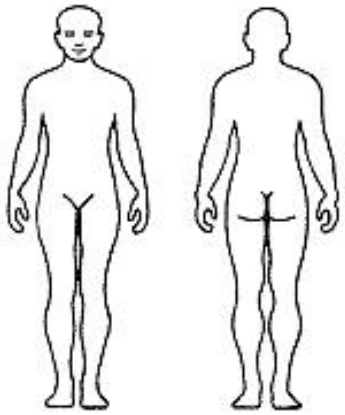
IN CASE OF EMERGENCY CONTACT:
Name_____
Relationship_____
Home phone_____
Cell phone_____

Auto Accident Insurance

Policy Number_____
Insurance Co. _____
Address_____
City_____State_____Zip_____
Adjusters Name_____
Adjusters Phone Number _____
Claim #_____
Date of accident_____
Patient relationship to insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Condition

What is your major symptom/problem?_____
When did your symptoms begin?_____
Is the condition getting ☐ Worse ☐ Better ☐ Same ☐ Unknown
Is this problem ☐ Constant ☐ Comes and goes
Mark an X on the picture where it hurts →
Circle the severity of your pain below:
(No Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)
How does it feel?: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____
How often do you have the pain? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are difficult to perform ☐ Sitting ☐ Standing ☐ Walking
☐ Driving ☐ Getting Up ☐ Lying down ☐ Bending



Health History

What treatment have you already received for your current condition? □ Medication □ Surgery □ Physical Therapy
□ Orthopedic □ Chiropractic Services □ None □ Other _____

Name and address of other doctor(s) who have treated you for your condition?_____
_____

Please describe the other doctor's treatment for this condition? _____
_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Chest X-Ray_____ Urine Test _____ MRI/CT/Bone Scan _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Auto Accidents	_____	_____
Surgeries	_____	_____

(S = Self M = Mother F = Father)

(Please indicate which **PAST** conditions have been experienced **BEFORE** your present complaint by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
□	□	□	AIDS/HIV	□	□	□	Pacemaker	□	□	□	Mononucleosis
□	□	□	Anemia	□	□	□	Epilepsy	□	□	□	Neck Pain
□	□	□	Arthritis	□	□	□	German measles	□	□	□	Osteoporosis
□	□	□	Asthma	□	□	□	Headaches/Migraines	□	□	□	Polio
□	□	□	Back Pain	□	□	□	Heart Trouble	□	□	□	Psychiatric Care
□	□	□	Bladder Trouble	□	□	□	Reproductive Disorder	□	□	□	Hepatitis
□	□	□	Bone Fracture	□	□	□	High Blood Pressure	□	□	□	Rheumatic Fever
□	□	□	Cancer	□	□	□	Hernia	□	□	□	Rheumatism
□	□	□	Chest Pain	□	□	□	Kidney Disorder	□	□	□	Scarlet Fever
□	□	□	Concussion	□	□	□	Bowel Control Loss	□	□	□	Stroke
□	□	□	Cataracts	□	□	□	Menstrual Cramps	□	□	□	Sinus Troubles
□	□	□	Diabetes	□	□	□	Multiple Sclerosis	□	□	□	Tuberculosis
□	□	□	Indigestion	□	□	□	Muscular Dystrophy	□	□	□	STD
□	□	□	Measles	□	□	□	Chicken Pox	□	□	□	Tumors/Growths

Other _____

Are you pregnant? □ Yes □ No Due Date? _____

Are you currently taking any medication? □ Yes □ No If Yes, please list_____

AUTHORIZATION

By signing below, I acknowledge full financial responsibility for services rendered by King Health Center, LLC and/or Dr. Gary King. We are unable to submit claims to insurance companies; however, upon request from the patient we will provide an itemized statement which he or she may submit to their health plan for reimbursement.

Patient Signature _____ Date _____ Witness _____