Nicholas St. Hilaire, DC
4015 N. Armenia Ave.
Tampa, FL 33607
Phone:813 955-6742

Patient Name: _____ Birthdate: _____ Height: _____

Social Security Number: _____ Weight: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Who Referred You to Our Office? _____

Emergency Contact: _____ Relation: _____ Phone: _____

What are You Seeing the Doctor For? Headache ____ Neck Pain ____ Back Pain ____ Other _____

Primary Care Physician: _____

May We Send Health Updates to this Physician? ____ Yes ____ No

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Group #		
Subscriber ID:		
Address:		
Insured's Name:		
Insured's Employer:		
Insured's SS#		
Relation / DOB:		

Martial Status: ____ Single ____ Married ____ Divorced ____ Widowed

Current Work Status: ____ Employed ____ Retired ____ Not Working ____ Light Duty

Occupation: _____

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

REVIEW OF SYSTEMS

Have you noticed any of the following?

- _ Unexpected weight loss or gain
- _ Blurred / double vision
- _ Headache
- _ Chest pain
- _ Shortness of breath
- _ Nausea
- _ Painful urination
- _ Joint pains
- _ Skin rash
- _ Dizziness
- _ Depression
- _ Easy bruising
- _ Excessive thirst or urination
- _ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

- _ Hypertension
- _ Coronary Artery Disease
- _ Arthritis
- _ Cancer
- _ Overweight
- _ Osteoporosis
- _ Immune Disorder
- _ Other: _____

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

- _ Cancer
- _ Stroke
- Hypertension
- _ Alcoholism
- _ Bleeding tendency
- Other:

Everything I have answered is true and correct to the best of my knowledge.

Signature:_____ **Date:** _____