Gentle Mobile Care

813-390-3009

Dr. Ilyne Kobrin Urbanovich, D.C. **PO Box 20454 | Tampa, FL 33622**

Dr. Lexy Ballinger, L.Ac.

PATIENT INFORMATION

Instructions: Please complete form to the best of your ability prior to your first visit.

Patient Name: _____ **DOB:** _____
Community Name, Address and Apartment: _____
Contact Phone Number(s): **(M)**_____ **(H)**_____
Email:_____
Who may we thank for referring you? _____
Height:_____ **Weight:**_____ **Dominant Hand:** ☐ **R** ☐ **L**

Emergency Contact Name: _____ **Relationship:** _____
Emergency Contact Phone:_____

Please share your health concerns.

_____
_____
_____

What can we help you with today?

_____
_____
_____

When did it begin?

_____
_____

Have you had any other treatment, tests for this condition? If so what?

_____
_____
_____

Was that treatment effective?

_____
_____

List your activities that are affected by your concerns.

_____
_____
_____
_____

List all current medications and vitamins below:

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Patient Name: _____ DOB: _____

What activities do you enjoy?

Is anything currently preventing you from participating in those activities

How many hours do you sleep each night? _____ Do you take naps? Y / N

How many meals do you eat each day? _____

About how much water or other fluids do you drink each day? _____

How much coffee/tea do you drink each day? _____

Do you smoke? Y / N

Do you drink alcohol? Y / N If Yes, how many drinks per week? _____

Are you using CBD oil or other medical marijuana products? Y / N If Yes, which? _____

Who do you call in case of emergency?

Name	Relationship	Phone Number

May we discuss information regarding your treatment and care with him/her? Y / N
Please list anyone else with whom we are authorized to discuss information regarding your treatment and care.

Name	Relationship	Phone Number

I authorize Dr. Ilyne Kobrin Urbanovich, DC to discuss and release information with the individuals listed above. This authorization will remain in effect until terminated in writing.

Printed Name: _____ Signature: _____ Date: _____

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Patient Name:_____

DOB: _____

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PATIENT QUESTIONAIRE

Place an X next to those that apply:

GENERAL SYMPTOMS

- ☐ Memory problems
- ☐ Balance issues
- ☐ Pain and/or difficulty moving
- ☐ Heart disease
- ☐ Digestive issues
- ☐ Breathing issues
- ☐ Vision or hearing loss
- ☐ Oral health issues
- ☐ Cancer
- ☐ Frequent headaches
- ☐ Fever / chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Fatigue
- ☐ Anxiety
- ☐ Depression
- ☐ Weight loss
- ☐ Weight gain
- ☐ Numbness in hands
- ☐ Numbness in feet
- ☐ Allergies

BONES & JOINTS

- ☐ Low back pain or stiffness
- ☐ Mid back pain or stiffness
- ☐ Neck pain or stiffness
- ☐ Rib pain
- ☐ Hip pain or stiffness R☐ L☐
- ☐ Knee pain or stiffness R☐ L☐
- ☐ Foot pain or stiffness R☐ L☐
- ☐ Shoulder pain or stiffness R☐ L☐
- ☐ Elbow pain or stiffness R☐ L ☐
- ☐ Wrist pain or stiffness R☐ L☐
- ☐ Hand pain or stiffness R☐ L☐
- ☐ Gout
- ☐ Osteoporosis
- ☐ Fractured bone, year _____

Have you been diagnosed with:

- ☐ Hepatitis
- ☐ AIDS
- ☐ HIV
- ☐ TB
- ☐ Cancer (location and year) _____
- ☐ Blood clots (location and year)
- ☐ Overactive thyroid
- ☐ Underactive thyroid
- ☐ Diabetes

GASTROINTESTINAL

- ☐ Heartburn/reflux/GERD
- ☐ Poor appetite
- ☐ Difficult digestion
- ☐ Excess hunger
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Bleeding problems
- ☐ Hemorrhoids
- ☐ Ulcers
- ☐ Liver disease/cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Irritable bowel
- ☐ Chrohn's disease
- ☐ Colitis
- ☐ Other (specify)

HEART

- ☐ Heart attack, year _____
- ☐ Heart failure, year _____
- ☐ Stroke, year _____
- ☐ Aneurysm, year _____
- ☐ Heart valve problem
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Fast heart rate
- ☐ Slow heart rate
- ☐ Angina / heart pain
- ☐ Ankle swelling
- ☐ Poor circulation
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Other (specify) _____

LUNGS

- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Breathing difficulty
- ☐ Other (specify) _____