

# Colley Avenue Chiropractic and Bodyworks

1906 Colley Avenue , Norfolk, VA 23517

Phone: 757-627-3657

## Patient Information:

Date	_____	SSN	_____	Birthday	_____
First Name	_____	Middle Name	_____	Last Name	_____
Sex	<input type="radio"/> Male <input type="radio"/> Female	Height	_____	Weight	_____
Married/Civil Union:	_____	Spouse Name	_____	# of Children	_____
Home #	_____	Cell #	_____	Work #	_____
Address	_____				
City	_____	State	_____	Zip	_____
Emergency Contact	_____	Emergency Relation	_____	Emergency Phone	_____
Email	_____				

## Complaint Information:

Date of Onset (current episode): \_\_\_\_\_  Improving  Worsening  Staying the Same

Desc Discomfort: \_\_\_\_\_

Pain Level Rating - Scale 1 to 10: At its best: \_\_\_\_\_ At its Worst: \_\_\_\_\_ Current Level: \_\_\_\_\_ Frequency: \_\_\_\_\_

Same Condition Before:  Yes  No Initial Onset: \_\_\_\_\_ Received Treatment:  Yes  No

Injury Occurred:  Work  Automobile  Third-Party  Other Injury Date: \_\_\_\_\_

Describe Injury (basic): \_\_\_\_\_

\_\_\_\_\_

Seen anyone else for this condition:  Yes  No Practitioner(s): \_\_\_\_\_

Received Treatment:  Yes  No Explain: \_\_\_\_\_

X-rays / Imaging:  Yes  No Explain: \_\_\_\_\_

Aggravates Condition: \_\_\_\_\_

Improves Condition: \_\_\_\_\_

Interfere w/ Activities:  Yes  No Explain: \_\_\_\_\_

Missed Work:  Yes  No Unable to Work from: \_\_\_\_\_ Unable to Work Until: \_\_\_\_\_

Reduced Work:  Yes  No Explain: \_\_\_\_\_

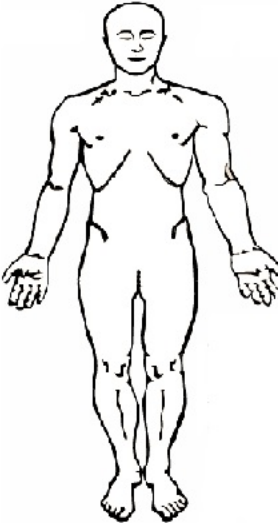
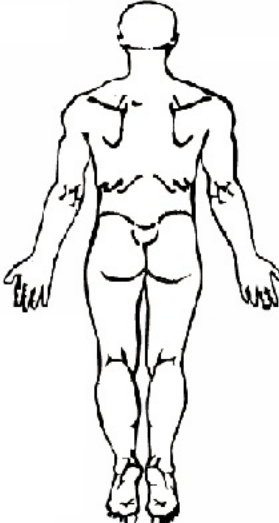
Affected Sleep:  Yes  No

Affected Appetite:  Yes  No

Weather Affects it:  Yes  No

**Symptoms:**

- Ache / Dull
- Sharp / Stabbing
- Numb / Tingling
- Pins & Needles
- Burning
- Throbbing
- Cramping
- Radiating
- Other Pains

## Personal Health History

Previous Chiro Care:	<input type="radio"/> Yes <input type="radio"/> No	Date:	_____	Condition(s) treated:	_____
Other Health Conditions:	_____				
Medications:	_____				
Supplements:	_____				
Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____
Phys City:	_____	Phys State:	_____	Phys Zip:	_____
Physical Activity:	_____				
Work Activities (basic):	_____				
Other Physical Activity (if applicable):	_____				
[Women Only]					
Past Childbirth:	<input type="radio"/> Yes <input type="radio"/> No	# of Deliveries:	_____	<input type="radio"/> Natural	<input type="radio"/> Caesarian
Complications:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Chance Pregnant:	<input type="radio"/> Yes <input type="radio"/> No	Planning:	<input type="radio"/> Yes <input type="radio"/> No		

## Personal Incident History:

Auto Accident:	<input type="radio"/> Yes <input type="radio"/> No	Date(s):	_____		
Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Struck Unconscious:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Broken Bones:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Sprains/Strains:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Other Trauma:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Hospitalized:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Surgery:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Spinal Fusions:	_____	Implants, Plates, Pins, or Screws:	_____		

## Health Checklist:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aneurysm: _____             | <input type="checkbox"/> Arteriosclerosis          | <input type="checkbox"/> Arthritis- type(s): _____  |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Autoimmune Disease: _____ | <input type="checkbox"/> Bleeding Disorders         |
| <input type="checkbox"/> Breast Lump                 | <input type="checkbox"/> Bronchitis                | <input type="checkbox"/> Bruise Easily              |
| <input type="checkbox"/> Cancer- type(s): _____      | <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Chest Pain                 |
| <input type="checkbox"/> CHF                         | <input type="checkbox"/> Cold Extremities          | <input type="checkbox"/> Constipation               |
| <input type="checkbox"/> COPD/emphysema              | <input type="checkbox"/> Cramps                    | <input type="checkbox"/> CVA (stroke/TIA)           |
| <input type="checkbox"/> Dementia/Alzheimer's        | <input type="checkbox"/> Depression                | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Diagnosed emotional/mental  | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Eating Disorder            |
| <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Excessive Menstruation    | <input type="checkbox"/> Eye Pain or Difficulties   |
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Frequent Urination        | <input type="checkbox"/> Gallbladder disease/stones |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Headache                   |
| <input type="checkbox"/> Hemorrhoids                 | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Hot Flashes                |
| <input type="checkbox"/> Irregular Heart Beat        | <input type="checkbox"/> Irregular Menstrual Cycle | <input type="checkbox"/> Kidney Infection           |
| <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> Liver disease/cirrhosis   | <input type="checkbox"/> Loss of Balance            |
| <input type="checkbox"/> Loss of Memory              | <input type="checkbox"/> Loss of Smell             | <input type="checkbox"/> Loss of Taste              |
| <input type="checkbox"/> Lung disease                | <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Migraines                  |
| <input type="checkbox"/> Osteopenia / Osteoporosis   | <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Parkinson's                |
| <input type="checkbox"/> Polio                       | <input type="checkbox"/> Postural Abnormalities    | <input type="checkbox"/> Prostate Trouble           |
| <input type="checkbox"/> Retinal Disease             | <input type="checkbox"/> Sciatica                  | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Shortness of Breath         | <input type="checkbox"/> Sinus Infection           | <input type="checkbox"/> Skin Sensitivity           |
| <input type="checkbox"/> Sleep Problems/Insomnia     | <input type="checkbox"/> Smoker (current or past)  | <input type="checkbox"/> Spinal Curvatures          |
| <input type="checkbox"/> Spondylolisthesis / Antero. | <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Swelling of Ankles/Legs    |
| <input type="checkbox"/> Swollen Joints              | <input type="checkbox"/> Thyroid Condition         | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Varicose Veins              | <input type="checkbox"/> Venereal Disease          |   |
| <input type="checkbox"/> OTHER: _____                |  |   |

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Bypass surgery        | <input type="checkbox"/> Coronary artery disease |   |

Do you have Diabetes? If so what type?

- Type I    Type II    Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- |                                       |                                  |                                  |                              |                                   |
|---------------------------------------|----------------------------------|----------------------------------|------------------------------|-----------------------------------|
| <input type="checkbox"/> Acid Reflux  | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Colitis | <input type="checkbox"/> IBS | <input type="checkbox"/> Ulcer(s) |
| <input type="checkbox"/> OTHER: _____ |                                  |                                  |                              |                                   |

## Family Health History:

Family Health History

No history of health conditions in my family to my knowledge

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

**Informed Consent to Chiropractic Care and Therapeutic Massage:** You have the right to be informed about your condition and the possible options for treatment. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care. When a patient seeks chiropractic care/ therapeutic massage, it is important for doctor/therapist and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment is a specific thrust into the misaligned joint that helps restore normal motion. This allows the nervous system to work better at keeping you healthy. Our licensed massage therapist use various techniques, such as neuromuscular reeducation, to allow neurological feedback to the muscles, fascia, soft tissues and nerves to aid in decreasing the tonicity of the muscles. This over time aids with the decrease of frequency of subluxation and myospasm(s). Please be aware that this office has semi-private treatment rooms. While in the adjustment area, you may be heard by other patients. In addition to the many benefits of chiropractic care and therapeutic massage, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel after starting care include muscle spasm, bruising, nausea, dizziness, fatigue and soreness. It is probable that it may subside after your first 3-5 visits. Severe risks such as nerve injury, fracture, and stroke are very rare with low percentage, but can occur. The techniques used in this office are very precise, which greatly decreases these risks. You are responsible for communicating to the doctor/therapist any past history of such health issues or concerns. There is no guarantee that the treatment will provide the expected or desired outcomes. Your lifestyle, including diet, exercise, health habits (water/caffeine intake/smoking/drinking) and stress level, are probable to directly affect your results. If, at any time, you have questions or concerns regarding your treatment please contact our office. The doctor will be happy to discuss your concerns.

I have read and understand the purpose of chiropractic care/therapeutic massage and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED. I CONSENT TO RECEIVE THE CHIROPRACTIC CARE/THERAPEUTIC MASSAGE DEEMED NECESSARY BY THE DOCTOR. I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

Signature \_\_\_\_\_

Date: \_\_\_\_\_