# 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 ○ Male ○ 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: ○ Yes ○ 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: ○ Yes ○ No # of Deliveries: ____ ○ Natural ○ Caesarian

Complications: ○ Yes ○ No Explain: ________

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

## Personal Incident History:

Auto Accident: ○ Yes ○ No Date(s): ________

Treatment: ○ Yes ○ No Explain: ________

Struck Unconscious: ○ Yes ○ No Treatment: ○ Yes ○ No Explain ________

Broken Bones: ○ Yes ○ No Treatment: ○ Yes ○ No Explain ________

Sprains/Strains: ○ Yes ○ No Treatment: ○ Yes ○ No Explain ________

Other Trauma: ○ Yes ○ No Treatment: ○ Yes ○ No Explain ________

Hospitalized: ○ Yes ○ No Explain: ________

Surgery: ○ Yes ○ No Explain: ________

Spinal Fusions: ________ Implants, Plates, Pins, or Screws: ________

## Health Checklist:

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

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

- ☐ Myocardial infarction
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Bypass surgery
- ☐ 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.

- ☐ Acid Reflux
- ☐ Crohn's
- ☐ Colitis
- ☐ IBS
- ☐ Ulcer(s)
- ☐ 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: ________