BROADNECK FAMILY CHIROPRACTIC

Marissa Wallie, DC Carrie F. Dugan, DC

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SSN**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How would you prefer to be addressed**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Telephone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cell**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Location**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Gender: M F Height**\_\_\_\_\_\_\_\_\_\_\_\_** Weight**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Marital Status S M D W Race**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Children Y N Ages**\_\_\_\_\_\_\_\_\_\_\_\_**

Specific reason for this visit **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Onset **\_\_\_\_\_\_\_\_\_\_\_** Sudden (explain) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** or Gradual Onset

Previous history of same or similar problem**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What makes it better **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** What makes it worse **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Intensity (on a scale of 0-10, 10 being the worst pain you can imagine **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Describe the symptom (sharp, numb, dull, tingling, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is it localized or does it radiate to another area **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Does it bother you constantly or come and go? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How does this interfere with your work or home life? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you been treated elsewhere for THIS complaint? Y N **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you currently being treated for any OTHER health issues or conditions, including pregnancy?

Y N If yes, please explain: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you currently experiencing or have you ever experienced health problems in the following areas (including, but not limited to):

Cardiovascular Respiratory Gastrointestinal

Neurological Musculoskeletal Opthalmological

Ear/Nose/Throat Endocrine Peripheral Vascular

Psychiatric Immunological Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is there a family history of any of the above problems? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(over, please)

Year & type of any surgeries**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Current medications/supplements**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Allergies**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Year & description of automobile accidents **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Year & type of other injuries (falls, sports, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Previous chiropractic care **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you exercise? Y N Type of exercise **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** how often? **\_\_\_\_\_\_\_\_\_\_\_\_**

Do you currently use tobacco? Y N Use alcohol? Y N Use recreational drugs? Y N

How do you manage stress? (Exercise, yoga, therapy, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you eat a diet rich in whole foods? (whole grains, fish, vegetables, fruits, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What color is your urine mid-day? Clear Pale Yellow Medium Yellow Dark Yellow

How many hours a night do you typically sleep? **\_\_\_\_\_\_\_\_**  What position? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you work outside the home, what are you physically doing most of the day? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Whom may we thank for referring you to our office? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Any other concerns or information that you feel is important that the doctor know **\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Informed Consent**

*I understand that chiropractic is not a treatment for any particular condition or disease, but rather a method of detection and correction of spinal misalignments. Acceptance of such treatment does not imply guarantee of results. There are certain risks associated with any treatment. The doctors at BFC will work within their scope of practice to minimize these risks, and will discuss available alternative treatments or risks that may pertain to you. Signature implies consent for treatment and release of information necessary to coordinate with other health care providers and to process insurance paperwork. I understand health insurance is a contract between me and my insurance company, and that I am ultimately responsible for all bills and payments rendered.*

**Signature of Patient or Guardian of Minor Patient Date**