Broadneck Family Chiropractic

Dr. Marissa Wallie, Dr. Carrie Dugan, Dr. Jennifer Scanlon

NEW PATIENT ADULT INTAKE

Name______________________________ Nickname ______________________

Date of Birth __________ Gender: ________ Height__________ Weight__________

Address______________________________ City/State/Zip______________________

Phone ______________________________ Email______________________

Occupation______________________________ Employer______________________

Location______________________________ Years on job______________________

Marital Status S M D W Race__________ Children Y N Ages______________

Emergency Contact (relationship)________________ Phone ______________

PURPOSE OF THIS VISIT

Reason for this visit (pain, pregnancy, wellness, etc)______________________

____

Females only: Are you pregnant? Yes No Due Date: ______________

Name of OB/GYN or Midwife: ______________________________

Where are you planning on birthing your baby? Hospital Home Birthing Center

Main complaint: ____

Date of Onset ___/___/___ Did it begin: Gradual Sudden Progressive over time

Intensity (on a scale of 0-10, 10 being the worst pain you can imagine)__________

What makes it better ____

What makes it worse ____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Is it localized or does it radiate/travel? ______________________________

Does it bother you constantly or come and go? ______________________________

Does the complaint interfere with: Work Sleep Hobbies Daily Routine

Explain: ____

Previous history of same or similar problem: Yes No Explain:______________

Who have you seen for this? ______________ What did they do?______________

Secondary complaint: ____

Date of Onset ___/___/___ Did it begin: Gradual Sudden Progressive over time

Intensity (on a scale of 0-10, 10 being the worst pain you can imagine)_______________

What makes it better ____

What makes it worse ____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Is it localized or does it radiate/travel? _______________________________

Does it bother you constantly or come and go? ___________________________

Does the complaint interfere with: Work Sleep Hobbies Daily Routine

Explain: ____

Previous history of same or similar problem: Yes No Explain:_______________

Who have you seen for this? __________________ What did they do?______________

What are your goals for care in our office? _______________________________

____

How would you describe yourself (check all that apply)

_Happy _Sad _Spiritual _Angry _Depressed _High Energy _Low Energy

_Stubborn _Open-Minded _Close-Minded _Faith Based _Analytical _Optimistic

Health Conditions

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):

- ☐ Neck pain
- ☐ Sinus Issues
- ☐ Shortness of breath
- ☐ Pain in hips/legs
- ☐ Menstrual Problems
- ☐ Pain into arms
- ☐ Allergies
- ☐ Asthma
- ☐ Sciatica
- ☐ Sexual Dysfunction
- ☐ Numbness/Tingling
- ☐ Recurrent Colds/Flu
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Cancer
- ☐ Headaches/Migraine
- ☐ Low Energy
- ☐ Heartburn/Reflux
- ☐ Muscle Cramps in Legs
- ☐ Multiple Sclerosis
- ☐ Dizziness/Vertigo
- ☐ Heart Palpitations
- ☐ Nausea
- ☐ Constipation or Diarrhea
- ☐ Sleep Apnea
- ☐ Vision Problems
- ☐ Heart Murmurs
- ☐ Ulcers
- ☐ Bladder Infections
- ☐ Trouble Sleeping
- ☐ Thyroid Issues
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Difficulty Urinating
- ☐ Anxiety/Depression
- ☐ Kidney Stones

Family history of any of the above problems? ______________________

Surgeries (name and year) ______________________

____

Current medications/supplements (prescription and over the counter ______________________

____

Allergies______________________

Previous chiropractic care: Yes No When: ______________________

Do you exercise? Yes No Type: ______________ How often? ______________

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

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

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you, so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, spinal surface EMG, spine thermography, palpation, specialized instrumentation, referral for further imaging and/or laboratory testing.

Adjustments are made by chiropractors in order to correct or reduce spinal and joint misalignments. The Chiropractic adjustment is the application of a precise movement and/or force into the joint in order to reduce misalignment(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol.

Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life. Acceptance of such treatment does not imply guarantee of results.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated. Risks associated with some chiropractic treatment may include: soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because stroke may cause a serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that care may not accomplish the desired objective. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE *Dr. Marissa Wallie, Dr. Carrie Dugan, Dr. Jennifer Scanlon* TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

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