



MidValley Chiropractic Clinic

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Dr. Woodmansee, DC

Dr. Bryan Gordon DC

Patient Information

Today's Date _____ Chart # _____

Patient Name: _____

Address: _____

Street

City

State

Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ : May we send you periodic information Via Email? Y N

Sex: M/ F Age: _____ Birth Date: _____ Patient SS#: _____

Brief Job Description: _____ Company : _____

Emergency Contact: _____ Phone Number: _____

Accident Information

Is this condition due to an accident? Yes/ No _____ Date of Accident: _____

Type of Accident? Auto/ Work/ Home/ Other _____

Have you reported your accident to Insurance, employer, or work comp.? Yes/ No explain: _____

Attorney Name (if applicable) _____ Your Auto Insurance Company: _____

Injury Claim # _____ Name of Adjuster: _____

Phone Number of Adjuster: _____

Experience With Chiropractic

Have you seen a Chiropractic Physician before? Yes No Who? _____ When? _____

Reason for Visit at that time: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? yes No

Did you know poor posture affects your health? Yes No

Are you aware of any of your poor posture habits? Yes No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? yes no

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole back & body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? yes no

Signature: _____ Date: _____



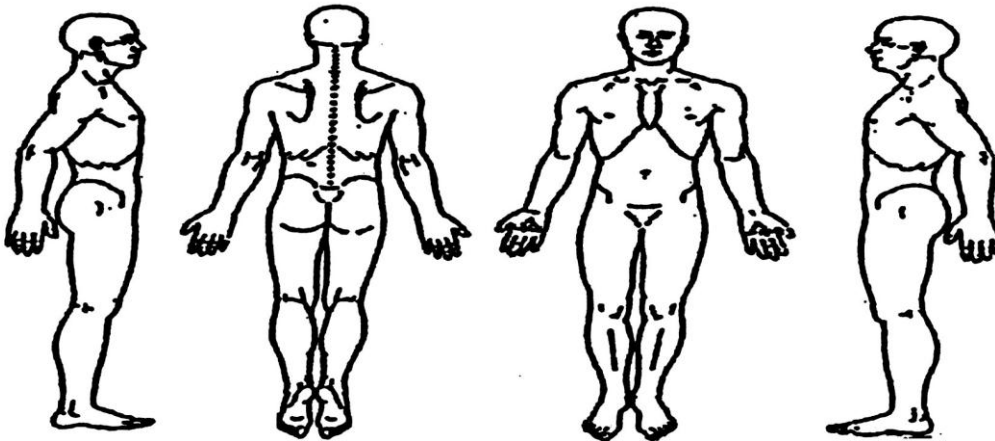
MidValley Chiropractic Clinic PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Neither

Your Present Complaint? _____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
- ER physician Orthopedist Other: _____
- Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
- Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	For Females Only
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

If yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ **Date:** _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health and we accept the patient for such care, it is essential for both to be working on the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infinity.

One disturbance to the nervous system is called vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as phtyiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommended that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient Signature _____ **Date:** _____



MidValley Chiropractic Clinic

Dr. Dirk Woodmansee

Dr. Bryan Gordon

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? (rear, side, T-bone, etc.) _____
10. Did your vehicle hit anything after the accident? if yes, please describe)

11. **Where were** you sitting in the vehicle during the accident? (ie: Driver, Passenger, Rear Passenger drivers or passenger side) _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
 - kept going straight
 - kept going straight hitting a car in front
 - was hit by another vehicle
 - spun around
 - spun around and hit a stationary object
 - hit a stationary object
18. Did you lose consciousness during the accident? - yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totaled

35. Choose the items that dented inward

- floorboards
- side door
- dashboard

36. Choose the doors that would not open as a result of the accident

- front left
- rear left
- front right
- rear right

37. Did you go to the hospital? If no, why and do not answer 38-43 _____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital

- pain medication
- muscle relaxors
- neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hospital ? If yes, which area was taken?
