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 <u>x-rays</u>? _____ yes ____ No
Did you know <u>poor posture</u> affects your health? ____ Yes ____ No
Are you aware of any of your <u>poor posture habits</u>? ____ Yes ____ No
Explain: ____
Are you aware of any poor posture habits in your <u>spouse or children</u>? ____ 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: ___________________

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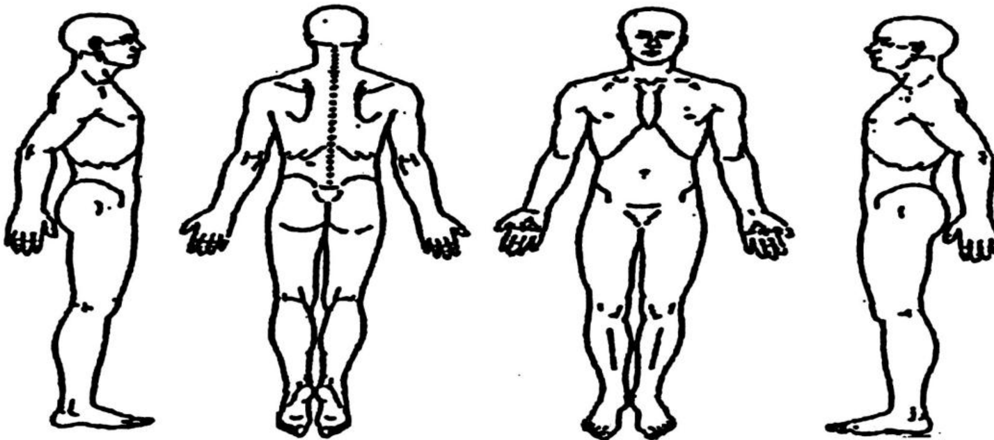
PATIENT INTAKE FORM

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?

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

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ 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 phtysiotherapy 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: ___________________