



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: _____



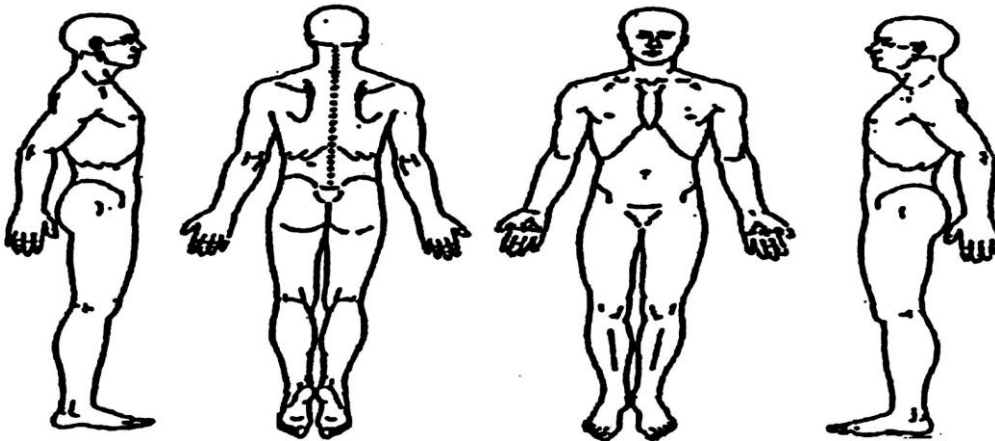
MidValley Chiropractic Clinic PATIENT INTAKE FORM

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

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 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: _____