



# ChiroWerx

Chiropractic and Bodywork

## Confidential Patient Information

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt# City State Zip Code

Marital Status: S M D W Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender M F

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who may we thank for your referral? Family Friend Community Ad Postcard Provider Other

Please specify \_\_\_\_\_

## YOUR PRESENT COMPLAINT \_\_\_\_\_

When did this current episode begin? Be specific (give a date) if possible: \_\_\_\_\_

Have you been treated by a physician for this condition in the last year? Yes No

Which word describes the frequency of your symptom? (check one)

- Constant (76% - 100% of awake time)
- Intermittent (26% - 50% of awake time)
- Frequent (51% - 75% of awake time)
- Occasional (0% - 25% of awake time)

Which phrases best describe *changes* in your symptoms during the day? (check all that apply)

- It is worse in the morning
- It is worse in the afternoon
- It is worse at night
- It changes with the weather
- It does not change

What helps *relieve* your symptoms? (check all that apply)

- Ice
- Heat
- Medication
- Nothing helps
- Other \_\_\_\_\_

What activities are limited by your discomfort? (check all that apply)

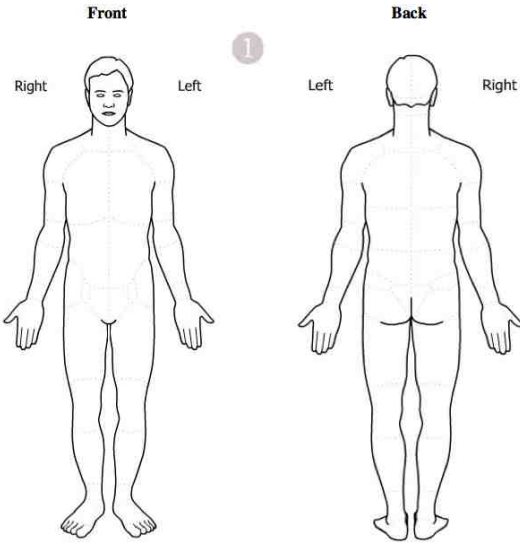
- Bending
- Coughing/ Sneezing
- Driving
- Getting up
- Lifting
- Lying Down
- Pulling
- Pushing
- Reading
- Sitting
- Sleeping
- Standing
- Turning Head
- Twisting at waist
- Walking
- Working
- Other \_\_\_\_\_



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Identify your areas of discomfort by marking the affected body parts in the illustration.



Smoking status:  Every day  Some day  Former  Never

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many days do you exercise each week? \_\_\_\_\_

Have you ever been diagnosed with any allergies? No Yes

If yes, please explain \_\_\_\_\_

Are you pregnant? No Yes Date of last cycle: \_\_\_\_\_

List all over-the-counter medications being taken. \_\_\_\_\_

List all vitamins or other dietary supplements being taken. \_\_\_\_\_

List all prescription medications being taken. \_\_\_\_\_

Describe any operations you have had and the dates: \_\_\_\_\_

Have you ever been diagnosed with cancer? No Yes If yes, please explain: \_\_\_\_\_

Has anyone in your family ever been diagnosed with cancer? No Yes If yes, please explain \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if ChiroWerx, PLLC extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at ChiroWerx, PLLC and whomever they may designate as assistants, to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination and treatment. I certify that the above information is true and correct.

A no-show fee of \$30 will be charged if cancellations or re-schedules aren't made within 24 hours of your appointment time.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## PAST, FAMILY, AND SOCIAL HISTORY

### PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

#### Illnesses:

- Asthma
- Autoimmune Disorder (Type) \_\_\_\_\_
- Blood Clots
- Cancer (Type) \_\_\_\_\_
- CVA/ TIA (Stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: \_\_\_\_\_

#### Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: \_\_\_\_\_

#### Hospitalizations: (Non-surgical with Date)

\_\_\_\_\_

#### Surgeries: (If yes, provide type & surgery date)

- Cancer \_\_\_\_\_
- Orthopedic
  - Shoulder – L / R \_\_\_\_\_
  - Elbow/Forearm – L / R \_\_\_\_\_
  - Wrist/Hand – L / R \_\_\_\_\_
  - Hip – L / R \_\_\_\_\_
  - Knee – L / R \_\_\_\_\_
  - Ankle/Foot – L / R \_\_\_\_\_
- Spinal
  - Neck: \_\_\_\_\_
  - Back: \_\_\_\_\_
- Other: \_\_\_\_\_

#### Medical History Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown
- Unremarkable

#### Family History Comments:

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3
Gender	F	M						
Age at death (if deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SOCIAL AND OCCUPATIONAL HISTORY

#### Highest Level of Education:

- High School
- College
- Post Grad.
- Other

#### Alcohol Use:

- Every Day
- Weekly
- Occasionally
- Never

Social History Comments: \_\_\_\_\_

#### Caffeine Use:

- Coffee
- Tea
- Energy Drinks
- Soda
- Never

#### Exercise Frequency:

- Daily
- 3-4x/wk
- 2-3x/wk
- Rarely
- Never

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name (First MI Last) \_\_\_\_\_ Account # \_\_\_\_\_





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TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment.

I (We) voluntarily request Dr. Dunning as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition, which has been explained to me as: spinal/extremity muscle injury or condition, ligamentous or vertebral disc injury, "pinched nerve", vertebral or pelvic subluxation and/or extremity subluxation.

I (We) understand that the following integrative and complementary procedure(s) is planned for me and I (We) voluntarily consent and authorize these procedures: spinal and/or extremity manipulation, manual muscle therapies, physical therapy modalities also known as ultrasound, electrical muscle stimulation, heat/ice, and spinal intersegmental traction.

I (We) understand that no warranty or guarantee has been made to me as to the result of care.

I (We) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I (We) believe that I (We) have sufficient information to give this informed consent.

I (We) certify this form has been fully explained to me, that I (We) have read it or have had it read to me and that I (We) understand its contents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date