Broadway Family Chiropractic

Center. Heal. Renew.

NEW PATIENT FORM

Welcome to Broadway Family Chiropractic! The purpose of this office is to educate as many families as possible about the spinal condition where the spine shifts out of alignment known as ***Vertebral Subluxation***. Vertebral Subluxation destroys an optimal spine and your ability to have Optimal Health. Your experience at this office will not only be of healing but also of learning how your body functions and how you can best take care of it. Our goal is to help you to **Center, Heal and Renew.**

Yours in Health, Dr. Margie Downes

PLEASE COMPLETE ALL QUESTIONS. PLEASE PRINT.

Name:_____ Nickname:_____ Today's Date: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Marital Status: M W D S Partnered

Employer/School: _____Occupation: _____

Spouse/Partner's Name: _____Occupation: _____Cell#: _____

Kid's Names & Ages: _____

Kid's or Other Family Members health concerns: _____

Are you possibly/currently pregnant: Y N If yes, when are you due: _____

When did you last see a chiropractor:_____Reason:_____Dr._____

Your favorite hobbies: _____

Who may we thank for referring you: _____

Are you here due to a recent auto or work injury: YN Date of Injury: _____

Other Doctors you've recently seen: _____

Who is financially responsible for this bill: _____

Insurance: BCBS Medicare GIC Harvard Pilgrim WellPoint Other:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Broadway Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to BFC will be credited to my account. <u>However</u>, I clearly understand and agree that <u>I am personally responsible for payment.</u> I understand that all first day visit charges are payable when services are rendered.

_____ _____ _____

Patient Signature | Guardian Signature Authorizing Care for a Minor | Date

HOW CAN WE HELP YOU?

Health Concerns: List Main Concern First	Rate of Severity 1=Mild 10=Unbearable	How often do you have these symptoms?	When did this episode start?	If you had the condition ever before, when?	Did the problem begin with an injury?
#1					
#2					
#3					

Please mark the areas on the diagram with the following letters to describe your symptoms:

N = Numbness/Tingling

T = Tight/Stiff

D = Dull

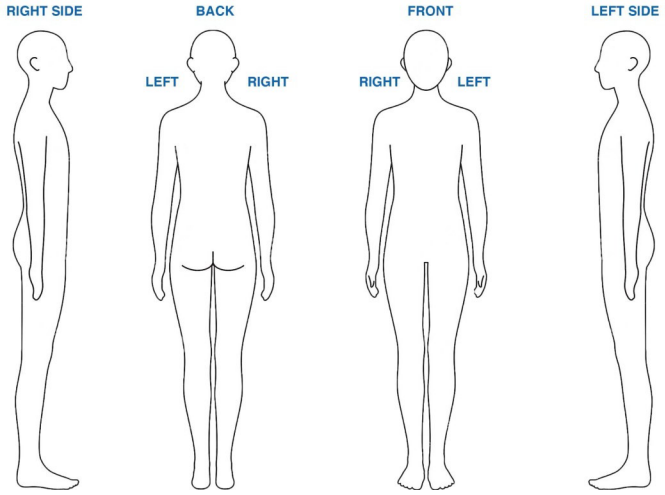
A = Aching

C = Cramping

S = Sharp/Stabbing/Shooting

B = Burning

Other:_____



IMPACT OF YOUR SYMPTOMS

How are your health concerns interfering with your life? Check where appropriate.

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					**Energy**				
Exercise					**Attitude**				
Recreation					**Patience**				
Relation-ships					**Productivity**				
Sleep					**Creativity**				
Self-Care					**Other:**				

Specifically, what is your #1 health concern keeping you from doing what you need to do, have to do or want to do?

_____

If you didn't have this health issue, what could you do better?_____

PATIENT WELLNESS ASSESSMENT

What are your health goals?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

How committed are you to correcting your health issue(s)? Please circle.

1 2 3 4 5 6 7 8 9 10

Not Committed — Very Committed

HISTORY OF PHYSICAL TRAUMA

Please list past surgeries, adult & childhood injuries, slips/falls, sports injuries, fractured bones and/or motor vehicle/ motorcycle accidents. Approximate dates for trauma is helpful.

_____

_____

_____

_____

HEALTH & ILLNESS HISTORY Please circle any condition that you have or have had.

ADD/ADHD	Depression	Immune Issues/Frequent Colds	Shoulder Issues
Anxiety	Diabetes	Knee Issues	Sports Injuries
Arthritis	Digestive Issues constipation, diarrhea, reflux, heartburn, IBS	Neurologic Issues type: _____	Stress/Tension
Asthma/Allergies	Dizziness/Vertigo	Neck Pain	TMJ Issues
Back Pain - middle around shoulder blades	Elbow/Wrist/Hand Issues	Previous/Current Abuse physical, mental, sexual	Urinary Issues
Back Pain - lower	Fatigue	Reproductive Issues menstrual irregularity, fertility	Osteoporosis
Cardiovascular Issues heart disease, high blood pressure, cholesterol	Foot/Ankle Issues foot/leg neuropathy	Ringing in Ears/Earaches	Other: _____
Cancer type: _____	Headaches/Migraines	Scoliosis	_____ _____
Concussion	Hip Issues	Sinus Issues	

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Allergies: _____

Medications: _____

_____

Supplements: _____

_____

Terms of Acceptance/Informed Consent

When a patient seeks Chiropractic Care and we accept a patient for such care, it is essential for us to be working toward the same objective. Chiropractic has only one goal. 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. Vertebral Subluxation is a misalignment in the spinal column which causes interference in the brain to body communication. Chiropractic adjustments facilitates the body's correction of Vertebral Subluxation. We do not diagnose or treat any disease or condition other than Vertebral Subluxation. Our only method to assist the body is through specific adjusting. Each patient needs to understand that all forms of health care include some risks and that by consenting to being a patient, they are relying on the Doctor to exercise her best judgment during all procedures that are in their best interest. **I have read and fully understand the previous statements.**

_____ _____ _____

Patient Signature Guardian Signature Authorizing Care for a Minor Date