Brentwood
Chiropractic Clinic

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Welcome to Brentwood Chiropractic and Massage Clinic. Please read the following so you may familiarize yourself with what steps will occur on your visit today, as well as upcoming visits.

1. **STEP ONE:**
   All new patients are requested to fill out a personal health / history questionnaire.

2. **STEP TWO:**
   Review of health history, review of condition, and preliminary examination.

3. **STEP THREE:**
   Chiropractic, Orthopedic, and Neurological examinations will be conducted by your Doctor.

4. **STEP FOUR:**
   The doctor will advise you whether additional procedures such as X-ray tests are necessary.

5. **STEP FIVE:**
   You will be given a "Report of Findings." The doctor will inform you of your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. **STEP SIX:**
   After you receive your Report of Findings, your Doctor will explain your recommended course of care.

7. **STEP SEVEN:**
   Adjustments will begin and continue as scheduled until maximum correction for your condition has been obtained.

8. **STEP EIGHT:**
   A re-evaluation to quantify your spinal health progress will be completed and your care program may be modified.

9. **STEP NINE:**
   After maximum correction, a schedule of wellness care will be recommended.

PERSONAL HISTORY

Dear Practice Member:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will refer you to the appropriate practitioner.

Name: ______________________________ A.H.C. Ins. No.: ______________

Phone: Home: ______________ Office ______________ Cellular ______________

Address: ______________________________ Postal Code: ______________

Emergency Contact: ______________________________ Phone: ______________

Email Address: ______________________________

Marital Status: ________ Birthdate: ______________ (YYYY / MM / DD) Weight: ______ Height: ______ Children: ______

Employer: ______________________________ Occupation: ______________

How did you hear about our office (please circle one) Yellow Pages Sign Location Referral Facebook Website Google

For referral: Whom may we thank for referring you? ______________________________

Gender: Male _ Female _ Other _

CURRENT HEALTH CONDITION

Present Complaint: ______________________________

Have you had any previous treatment for this condition? ______________________________

When did this condition begin? ______________________________

What do you believe caused this condition? ______________________________

Are there others in your family with this same condition? ______________________________

Have you had any times loss from work for this condition? (If recent, list dates) ______________

Is this a WCB case? ______ Is this a motor vehicle accident? ______ Date of accident: ______________

Are you presently taking medication? (please list) ______________________________

When is the last time you really felt well? ______________________________

How important is your health to you on a scale of 1-10, 10 being most important? ______________

PAST HEALTH HISTORY

Major surgery/operations: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart ☐ Back ☐ Neck ☐ Leg ☐ Other ______________

Major accidents or falls: (please describe) ______________________________

Previous Chiropractic Care: Doctor's name and approximate date of last visit ______________

Have you been treated for any health condition in the last year? Y / N Family MD ______________

If yes, please explain: ______________________________

Check any conditions that are presently causing you a problem.
Please underline which were a problem in the past.

GENERAL

- ☐ headache
- ☐ numbness or pain in arms or legs
- ☐ ringing in ears
- ☐ whiplash
- ☐ fainting
- ☐ earache
- ☐ sore throat
- ☐ nose bleeds
- ☐ sinus problems
- ☐ asthma
- ☐ enlarged glands
- ☐ loss of weight
- ☐ hypoglycemia
- ☐ nervousness
- ☐ depression/confusion
- ☐ vision problems
- ☐ dental problems
- ☐ hearing problems

ORGANS

- ☐ frequent urination
- ☐ painful urination
- ☐ blood in urine
- ☐ bladder trouble
- ☐ kidney stones
- ☐ bed wetting
- ☐ prostate problems
- ☐ sexual dysfunction
- ☐ anemia
- ☐ thyroid
- ☐ excessive appetite
- ☐ gas/bloating
- ☐ nausea or vomiting
- ☐ constipation/diarrhea
- ☐ colitis
- ☐ black/bloody stool
- ☐ hemorrhoids
- ☐ liver trouble
- ☐ gall bladder trouble

SKIN

- ☐ eczema
- ☐ skin eruptions
- ☐ varicose veins

MUSCLE & JOINTS

- ☐ low back problems
- ☐ neck problems
- ☐ sore joints
- ☐ painful tailbone
- ☐ pain between shoulders
- ☐ spinal curvature
- ☐ arthritis
- ☐ sore muscles
- ☐ walking problems
- ☐ broken bones
- ☐ difficulty chewing/ clicking jaw
- ☐ ankle swelling
- ☐ limb pain

RESPIRATORY & HEART

- ☐ lung problems
- ☐ chronic cough
- ☐ spit up blood
- ☐ frequent colds/flu
- ☐ shortness of breath/ difficult breathing
- ☐ heart problems

FEMALES ONLY

- ☐ painful periods
- ☐ irregular cycle
- ☐ cramps, backache
- ☐ vaginal discharge/infection
- ☐ lump/pain in breast
- ☐ menopausal symptoms
- ☐ previous miscarriage
- ☐ unable to get pregnant
- ☐ hot flashes
- ☐ are you pregnant? ☐ yes ☐ no ☐ not sure
- ☐ when was your last period? ____________

Check any of the following disease you have had:

☐ alcoholism ☐ venereal infection ☐ epilepsy ☐ stroke ☐ arthritis ☐ hypoglycemia
☐ tuberculosis ☐ rheumatic fever ☐ diabetes ☐ cancer ☐ allergies ☐ heart disease

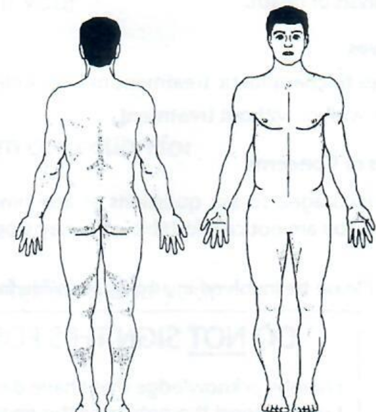
Has anyone in your family had any of the following diseases?

☐ heart disease ☐ high blood pressure ☐ cancer ☐ stroke ☐ arthritis

HABITS

	None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Stress	☐	☐	☐	☐

Please outline on the diagram the area of your discomfort.



Make a mark (x) along the line at the point which you think represents your current level of pain today in your major area of injury, somewhere between "No Pain at All" and "Pain as Bad as it Could Be."

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where is can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_______________________________ Date: ____________ 20______.
Name (please print)

_______________________________ Date: ____________ 20______.
Signature of patient (or legal guardian)

_______________________________ Date: ____________ 20______.
Signature of Chiropractor