Cherry Street Chiropractic
Dr. Justin Brame ~ Chiropractor

PRACTICE MEMBER HISTORY & INFORMATION

Date_____

Name_____ What do you prefer to be called?_____

Address_____

City_____ State_____ Zip_____

Telephone (H W Cell)Cell_____ (H W Cell)Work_____

Email address_____←**Please print clearly** (Used for closings, all receipts, essential notifications, schedule changes, bulletins, etc….Your information will be protected, we promise!)

Date of Birth_____Spouse/Partner's Name_____No. of Children_____

Occupation_____Employer_____

Emergency Contact (Name) _____ Phone Number _____

How did you hear about this office?_____

Previous Chiropractic Care? NO If yes, time & frequency under care?_____

Reason for discontinuing care?_____ Good experience? YES

What have you heard about Chiropractic?_____

_____

Major Medical History (please include all health conditions for which you've been treated or suffer from)

_____

_____

Have you ever had any Surgeries / Hospitalizations? If yes, please list (including dates): _____

_____

Have you ever had any Traumas / Falls / Accidents? If yes, please list (including dates): _____

_____

Do you take any Drugs / Medications / Supplements? If yes, list: _____

_____

Exercise_____ Hobbies_____

Stress: Work_____ Personal Life_____ Health_____ General Worry_____
Please rate from 1 (bliss) to 10 (nervous breakdown)

REASON FOR VISIT – OR – SIGNS OF LOSS OF HEALTH

The reason for this visit is a result of (please circle): Unknown

Work Sports Auto Trauma Chronic Repetitive Movement Unknown

EXPLAIN WHAT HAPPENED: _____

_____

Pain or Problem Started: _____

Pain/Symptoms are: Constant_____ Intermittent_____ % of the day

(please rate on a scale of 1-10 with 10 being the worst) →→ → Sharp_____ Dull__ Achy_____ Throbbing _____ Burning_____

What activities aggravate your condition or pain? _____

What activities lessen your condition or pain? _____

Is the condition worse during certain times of the day? _____

Is the condition interfering with: Work?_____ Sleep?_____ Home Life? _____ Other?_____

Please Explain: _____

Is the condition progressively getting worse? _____

Have you seen other doctors for this condition? _____

What treatments or home remedies have you tried? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU <u>ARE EXPERIENCING CURRENTLY</u>:

_____ Low Back Problems	_____ Pain between shoulders	_____ Neck Problems
_____ Swollen Joints	_____ Painful Joints	_____ Stiff Joints
_____ Vision Changes	_____ Loss of Feeling	_____ Paralysis
_____ Convulsions	_____ Forgetfulness	_____ Numbness/Tingling
_____ Sore throats	_____ Nausea	_____ Broken Bones
_____ Arm Problems	_____ Leg Problems	_____ Sore Muscles
_____ Weak Muscles	_____ Walking Problems	_____ Dizziness
_____ Fainting	_____ Headaches	_____ Muscles Jerking
_____ Sinus Problems	_____ Persistent Cough	_____ Sleep Problems
_____ Bladder Problems	_____ Constipation	_____ Diarrhea

_____ Other Problems (please list) _____

Smoke: **Drink:** **Eat Healthy:**

REVIEW OF SYSTEMS

The following list of conditions may seem unrelated to the reason you are seeking care; however, these problems may influence your overall diagnosis, care plan, and whether your case is accepted in this office.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES YOU <u>HAVE EVER HAD:</u>

- ❒ Appendicitis
- ❒ Scarlet Fever
- ❒ Diptheria
- ❒ Pleurisy
- ❒ Pneumonia
- ❒ Rheumatic Fever
- ❒ Polio
- ❒ Malaria
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Anemia
- ❒ Measles
- ❒ Mumps
- ❒ Chicken Pox
- ❒ Alcoholism
- ❒ Diabetes
- ❒ Cancer
- ❒ Heart Disease
- ❒ Goiter
- ❒ Lumbago
- ❒ Eczema
- ❒ H.I.V. Positive
- ❒ Venereal Infection
- ❒ Arthritis
- ❒ Epilepsy
- ❒ Mental Disorder
- ❒ Alzheimer's
- ❒ Dementia

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD <u>IN THE PAST 6 MONTHS:</u>

<u>Musculo-Skeletal System</u>

- ❒ Low Back Pain
- ❒ Pain Between Shoulders
- ❒ Neck Pain
- ❒ Arm Pain
- ❒ Joint Pain/Stiffness
- ❒ Walking Problems
- ❒ Difficulty Chewing/Clicking Jaw

<u>Nervous System</u>

- ❒ Numbness
- ❒ Paralysis
- ❒ Dizziness
- ❒ Forgetfulness
- ❒ Confusion/Depression
- ❒ Fainting
- ❒ Convulsions
- ❒ Cold/Tingling Extremities

<u>General</u>

- ❒ Allergies
- ❒ Loss of Sleep
- ❒ Fever
- ❒ Headaches

<u>Gastrointestinal System</u>

- ❒ Poor/Excessive Appetite
- ❒ Excessive Thirst
- ❒ Frequent Nausea
- ❒ Vomiting
- ❒ Diarrhea
- ❒ Constipation
- ❒ Hemorrhoids
- ❒ Liver Trouble
- ❒ Gall Bladder Problems
- ❒ Weight Trouble
- ❒ Abdominal Cramps
- ❒ Gas/Bloating After Meals
- ❒ Heartburn
- ❒ Black/Bloody Stool
- ❒ Colitis

<u>Genitourinary System</u>

- ❒ Bladder Trouble
- ❒ Painful/Excessive Urination
- ❒ Discolored Urine

<u>Cardiovascular & Respiratory</u>

- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ Blood Pressure Problems
- ❒ Irregular Heartbeat
- ❒ Heart Problems
- ❒ Lung Problems / Congestion
- ❒ Varicose Veins
- ❒ Ankle Swelling

<u>Ear, Eyes, Nose, & Throat</u>

- ❒ Vision Problems
- ❒ Dental Problems
- ❒ Sore Throat
- ❒ Ear Aches
- ❒ Hearing Difficulty
- ❒ Stuffed Nose

<u>Male/Female Systems</u>

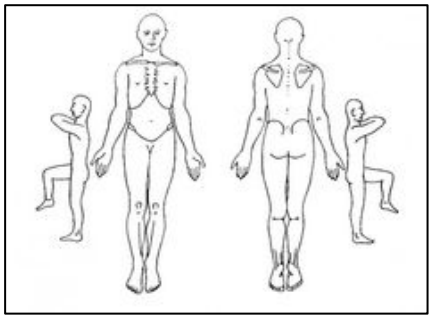
- ❒ Menstrual Irregularity
- ❒ Menstrual Cramping
- ❒ Vaginal Pain/Infections
- ❒ Breast Pain/Lumps
- ❒ Prostate/Sexual Dysfunction
- ❒ Genital Herpes

<u>FEMALES ONLY:</u>

When was your last period?_____

Are you pregnant?

❒ Yes ❒ No ❒ Maybe



Please mark the area(s) of your pain/discomfort on the diagram above.

<u>DO NOT WRITE BELOW THIS LINE</u>

Diagnosis:

Patient Accepted for Care: ❒ Yes / ❒ No / ❒ Additional Referral To:

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

INFORMED CONSENT & TERMS OF ACCEPTANCE

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health. Therefore, care in this office is limited to a single goal:

The detection and correction (or reduction) of vertebral subluxation.

Specifically, a **vertebral subluxation** is a misalignment of one or more of the 24 movable segments in the spine, which causes an alteration of nervous system function. This misalignment interferes with the transmission of mental impulses between the brain and (some or all of) the tissues, organs, glands, and cells that are controlled by that nerve. The end result is a lessening of the body's inborn ability to express its maximum potential for both health and performance.

The method employed for correction of vertebral subluxation is called a **chiropractic adjustment.** In this office, an adjustment is defined as the very specific application of force delivered to assist the body in correcting a misalignment of a bone.

A **chiropractic examination** will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

We do not offer to diagnose or treat any disease or medical condition as that is considered to be the practice of medicine. You will be advised; however, if any non-Chiropractic or unusual findings are noted during the course of your chiropractic examination. If you desire advice, diagnosis, or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or condition is called, we do not offer to treat it, nor will we offer advice regarding any treatment prescribed by others.

As medical conditions are not diagnosed or treated, ***health insurance policies do not typically cover the services in this office.*** For the same reason, we cannot participate in worker's compensation or personal injury cases nor will we complete disability forms, prescriptions, or referrals.

Again, our primary objective is to detect and correct vertebral subluxation in order to eliminate a major interference to the expression of the innate wisdom of the body.

Reported benefits of receiving care include (but are not limited to) increased adaptability to stressors, faster recovery from injuries, improved immune function, better sleep, increased energy, increased mobility, improved moods, better relationships, better posture, increased athletic and job performance, increased feelings of connection, reduced pain levels, significantly less need for drug therapy and/or surgery, and an overall higher quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. **The risks are seldom high enough to contraindicate care** and all health care procedures have some risk associated with them.

Risks associated with some chiropractic care may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with home care instructions, nutritional advice, and exercise recommendations may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. **Research and scientific evidence does NOT establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke**; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish my desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of receiving chiropractic care.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED.
ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.
HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Dr. Justin Brame, DC TO PROCEED WITH CHIROPRACTIC CARE.

_____ _____
Patient's Signature **Doctor's Signature**

_____
Date

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____

Signature: _____ **Relationship to Patient: _____**

Remarks: