WHAT TO EXPECT

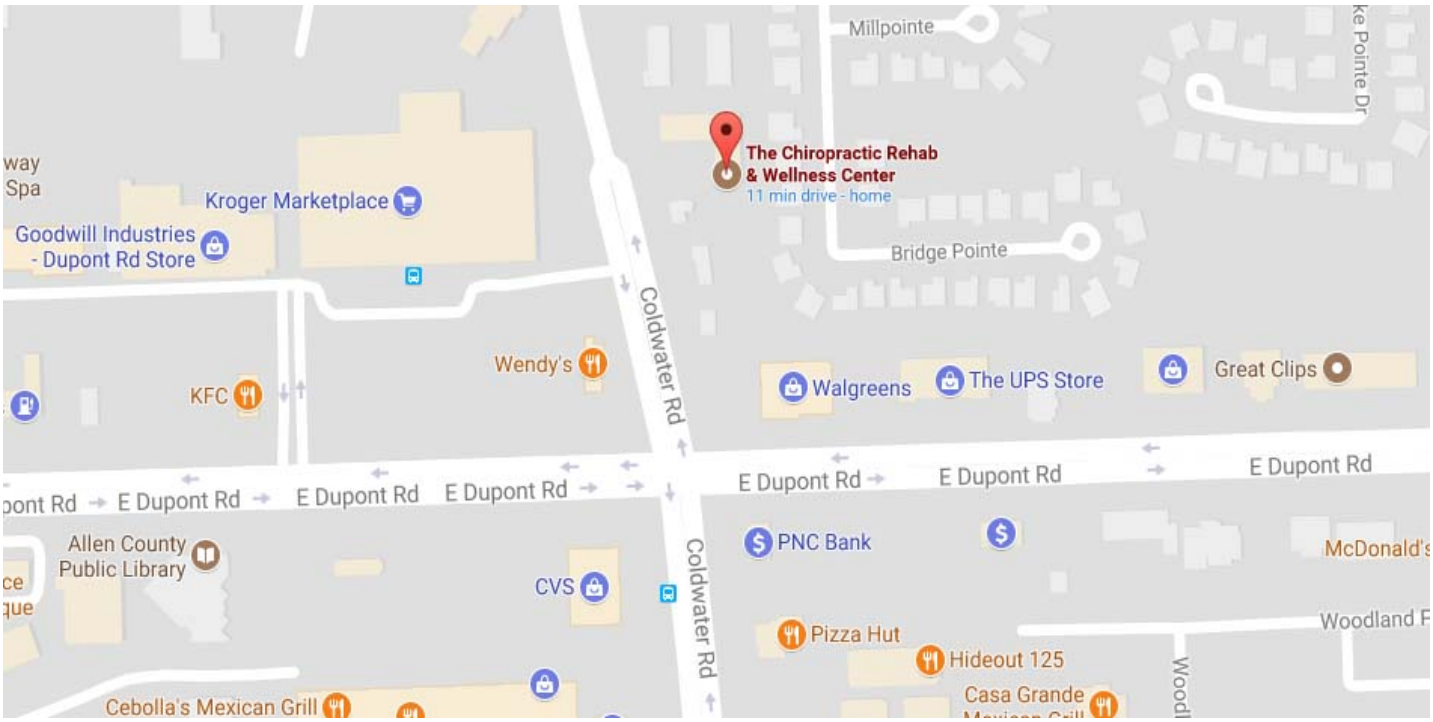
CHIROPRACTIC
REHAB & WELLNESS CENTER

10528 COLDWATER ROAD, FORT WAYNE, IN 46845
(260) 338-1700 *www.fortwaynechiro.com*

Your first visit is all about investigating the cause of your problem. It's only through a clear understanding of what's wrong that we can make our best recommendations for your care. Our chiropractic examination includes a physical exam. This first visit lasts about 30-45 minutes. After we have reviewed all of your test findings, we will schedule a report of findings where Dr. Miller will go through the details and prescribe a treatment plan to get you better as soon as possible . Asking questions is encouraged! Acceptance and understanding are important in the healing process.

We are located NorthWest at 10528 Coldwater road in Fort Wayne. We are close to the intersection of Dupont and Coldwater roads, across from Krogers. For more detailed directions call our office at (260) 338-1700.

APPOINTMENT DATE: TIME:



NEW PATIENT INFORMATION

The Chiropractic Rehab & Wellness Center

Welcome to our office! Please take whatever time needed to give us the following details about you, your life, and your health. If you do not understand any of these questions, please feel free to ask.

Confidential Patient information

Name: _____Social Security #_____-_____-_____
Home Phone:__(_____)_____-_____ Cell phone:__(_____)_____-_____
Address:_____City:_____ State:_____ Zip:_____
E-mail Address:_____@_____
Age:_____ Birthdate:_____ Marital status: M S W D
Occupation: _____ Employer:_____
Employer's address:_____Work phone: (_____)_____-_____
Spouse's name:_____Occupation:_____Employer:_____
How many children?_____ How were you referred to our office?:_____
Family medical doctor:_____When was your last physical examination?_____

Current Health Concern(s)

Primary reason for today's visit-please be as specific as you can.

_____

How do you believe your problem (pain) began?_____

Check the Severity of Your Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe)

The pain is present(circle one) 25% (occasional) 50% (sometimes) 75% (often) 100% (constant) of the day

When Did This Begin?_____ Experienced Previously? ☐ Yes ☐ Never When?_____

Is This Condition: ☐ Job Related ☐ Auto Accident ☐ Fall or Injury ☐ Other:_____

Have you lost work?_____ Day and date you last worked_____

Symptoms are worse in the: ☐ morning ☐ afternoon ☐ night

Symptom is: dull – tight – stabbing – shooting – tingling - annoying – sore – sharp – burning - pins & needles - aching

Has your condition? ☐ Improved ☐ Gotten worse ☐ Stayed the same since it began

Circle the problems that make it worse: sitting – standing – lying – activity – lifting-bending – walking - computer work - vacuuming taking care of kids – cleaning - preparing meals – yardwork – driving – shopping - taking out trash - sports:_____ stairs - self-care – sleeping - Twisting Other:_____

What makes it better: lying – rest – exercise – stretching – medication – walking – cold – heat - sittin - standing – activity – supplements Other:_____

Have you been treated for this before? ☐ No ☐ Yes How long ago?_____

What treatment did you receive?_____Other doctor's diagnosis:_____

Results of previous treatment? ☐ Good ☐ Poor Comments_____

2nd Complaint:_____ (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe) [25% 50% 75% 100%]

Symptom is: dull – tight – stabbing – shooting – tingling - annoying – sore – sharp – burning - pins & needles - aching

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.

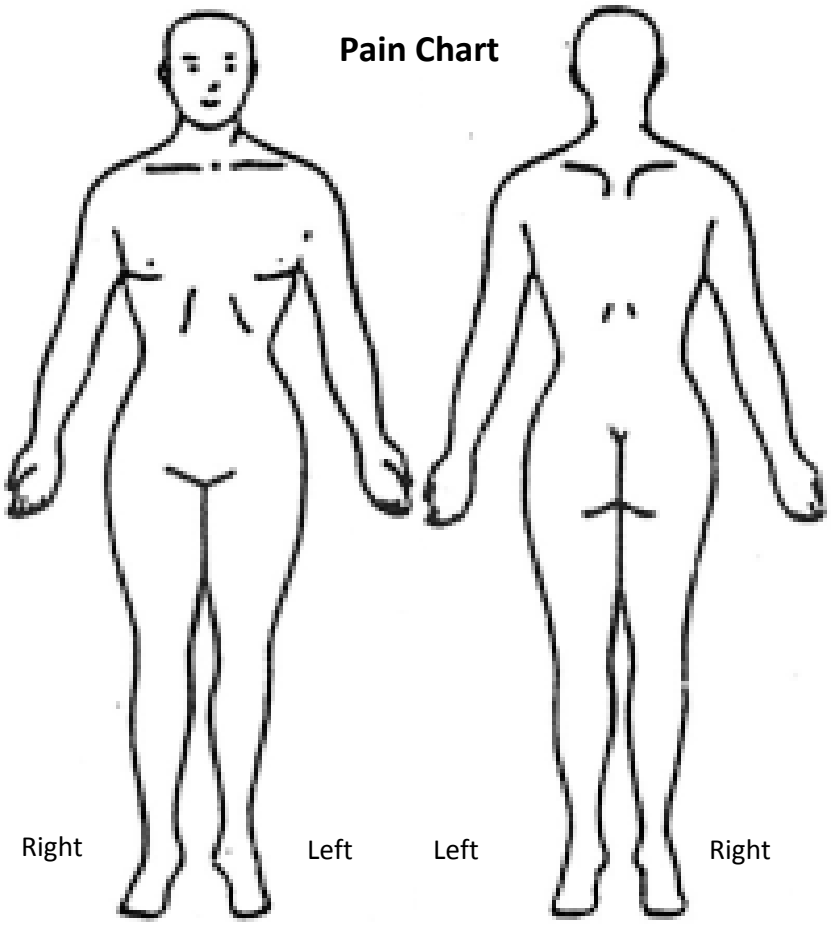
Use the appropriate symbols.

Mark areas of radiation.

Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 10
no pain severe pain

***What is this problem preventing you from doing that you really like to do**? (e.g.Playing w/grandchildren, exercise, sleeping, yardwork, affecting ability to work, etc.)_____

Current Medications:_____

Current Supplements:_____

Past Health History

Have you seen a chiropractor before? ☐ Yes ☐ No Who?_____
For what problem?_____ Were the results satisfactory? ☐ Yes ☐ No _____
What treatments were performed? ☐Manual adjustments ☐Instrument adjustments ☐massage therapy ☐rehab ☐nutrition/ supplements ☐Graston (scraping) ☐orthotics ☐decompression (traction) ☐Muscle stim or ultrasound therapy?
How long were you treated?_____ Last adjustment? ____/____/_____
Is there any history of spinal problems in your family? ☐ Yes ☐ No what?_____
Does anyone in your immediate or extended family receive chiropractic care? ☐ Yes ☐ No

What surgeries have you had?
1_____Year _____
2_____Year _____
3_____Year _____
4_____Year _____
5_____Year _____
6_____Year _____

Previous Fractures or Broken Bones: ☐ Yes ☐ No Describe:_____

Previous Falls or Auto Accidents: ☐ Yes ☐ No When:_____

Previous Hospitalization: ☐ Yes ☐ No Describe:_____

Give dates you have had any of the following (if exact date is unknown, give approximate date)

MRI_____ CT Scan_____ X-rays_____

Name of Doctor who ordered these tests:_____

Habits & Lifestyle

Do you exercise? ☐ Yes ☐ No How often? _____day(s) per week; Other:_____
What activities? ☐Walking ☐Running/Jogging ☐Weight Training ☐Cycling ☐ Yoga ☐Pilates ☐Swimming ☐_____
Do you smoke? ☐Yes ☐No How much? / How often? _____
Do you drink alcohol? ☐Yes ☐No How much? / How often? _____
Do you drink coffee? ☐Yes ☐No How much? / How often? _____

What are your hobbies? ☐Reading ☐exercising ☐sports fan:_____Team:_____ ☐gardening ☐cooking ☐video games ☐movies ☐shopping ☐other:_____

Any other concerns you wish to address or anything else you'd like to add?_____

_____

_____

_____

NEW PATIENT INFORMATION

Health Issues:

☐ Polio	☐ Arthritis	☐ Anemia	☐ Sleep Disorders
☐ Cancer	☐ AIDS or ARC	☐ Allergies	☐ Chronic Fatigue
☐ Diabetes	☐ Frequent Illnesses	☐ Seizure disorder	☐ Genetic Disorders
☐ High Stress	☐ Poor Diet	☐ Nervousness	☐ Over Weight
☐ Under Weight	☐ Asthma	☐ Bones	☐ Kidney Disorders
☐ Concussion	☐ Infections	☐ Other_____	

If Female, is there <u>any</u> possibility that you are pregnant? ☐Yes ☐ No

Check Any of the Following That May Apply To You

Muscles-Skeleton
- ☐ Low Back Pain
- ☐ Middle Back
- ☐ Neck
- ☐ Hips / Legs
- ☐ Joint Pain
- ☐ Shoulders/Arms

Circulation-Breathing
- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ High Blood Pressure
- ☐ Heart Rate
- ☐ Poor Circulation
- ☐ Coughing or Wheezing

Eye-Ear-Nose-Throat
- ☐ Eyes / Vision
- ☐ Dental / TMJ
- ☐ Throat / Voice
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage

Nerve System
- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Weak Muscles
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Seizures
- ☐ Cold Hands / Feet
- ☐ Stress Reactions
- ☐ Shaking / Tremors

Digestion-Elimination
- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss / Gain
- ☐ Heartburn
- ☐ Change In Stools

Urinary-Genitals
- ☐ Pain With Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Stream
- ☐ Bladder Control
- ☐ Genitals

Female Only
- ☐ Menstrual Problems
- ☐ Back Pain w/Period
- ☐ Breat Lumps/Pain
- ☐ Breast Implants

Family History

☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Alzheimer's
☐ Stroke	☐ Tuberculosis	☐ Circulatory Disorders	
☐ Cancer	☐ Back/Neck pain	☐ Previous Chiropractic care	
☐ Low back Surgeries	☐ Neck surgeries	☐ Other:_____	

Informed Consent

I hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/ adjustments, physical medicine, massage therapy, exercises, traction, graston, etc. I understand that the adjustments will involve movement of the joints and soft tissue that is considered to be one of the safest and most effective forms of therapy for neuromusculoskeletal problems. I am aware that there are possible risks/ complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows: soreness, uncomfortableness, joint injury, and C.V.A. Cerebral vascular accidents from chiropractic adjustments are extremely rare.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient signature:_____ Date:_____/_____/20_____