BROADWAY CHIROPRACTIC WELLNESS CENTER

P.O. BOX 533, 1510 N. Broadway New Ulm, MN 56073 (507) 359-4374

NAME_____ Date: ___/___/17

COMPLETE ADDRESS_____

DOB___/___/_____ MARITAL STATUS: M S W D # OF CHILDREN ____ RETIRED ___ YES ___ NO

PHONE: home ( )____-_____ work ( )____-_____ cell ( )____-_____ SS #_____

OCCUPATION_____EMPLOYER_____

IS THIS CONDITION WORK RELATED YES____ NO____ DID YOU MISS WORK YES____ NO____

DATE OF LAST PHYSICAL EXAMINATION____/____/____ BY WHOM_____

REFERRED TO OUR OFFICE BY_____

E-MAIL:_____@_____

Check areas you are interested in:

- □ BETTER HEALTH
- □ WEIGHT LOSS
- □ INCREASED ENERGY/FITNESS
- □ DETOX/CLEANSE PROGRAM
- □ MASSAGE THERAPY
- □ SAUNA
- □ WELLNESS PROGRAM
- □ CHIROPRACTIC MAINTENANCE PROGRAM
- □ NUTRITION PROGRAM
- □ DRUG FREE MANAGEMENT OF CHRONIC CONDITIONS

I herewith authorize Dr. F. Falentin to administer care to my daughter_____son_____

"PAYMENT ARRANGEMENTS ARE MADE AT TIME OF YOUR FIRST VISIT"

PERSON RESPONSIBLE FOR PAYMENT_____ARE YOU INSURED? YES____ NO____

_____(Initials) I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that BROADWAY CHIROPRACTIC will prepare any reports and forms necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to BROADWAY CHIROPRACTIC will be credited to my account upon receipt. **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.**

_____(Initials) I authorize this health care facility to release all information related to the care I receive, to my HMO, insurance company, third party payor, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headaches and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please don't hesitate to speak with your Doctor of Chiropractic.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, or disk injuries. **These are extremely rare occurrences.**

_____ _____

Signature of Patient or Responsible Party Date Relationship to Patient (if applicable)

Broadway Chiropractic PA 1510 North Broadway New Ulm MN 56073 507-359-4374

Patient Name: _____Date: _____2017

Please describe your symptoms/conditions using the outline below. Pick your symptoms/conditions by listing the most serious ones first. If you have more than two problems you can list them at the bottom according to severity. Dr. Falentin will address them in the future.

1st Condition/Symptom

Describe your symptom: _____When did it start: _____

How did it start: _____

How often do you experience your symptom?

① **constantly** (76-100% of the day)

② **Frequently** (51-75% of the day)

③ **Intermittently** (26-50% of the day)

④ **Occasionally** (0-25% of the day)

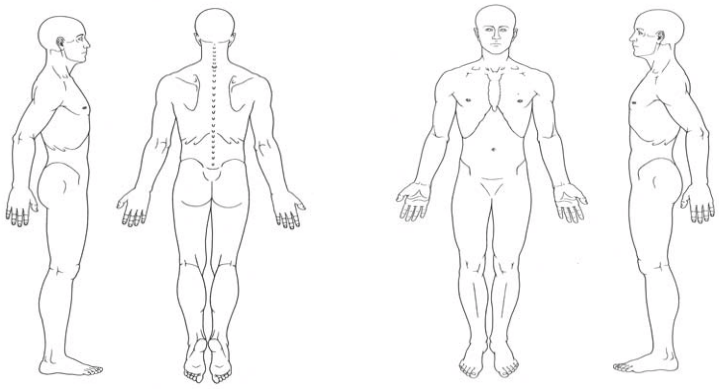
Describe the nature of your symptom:

① **Sharp** ② **Dull ache** ③ **Numb**

④ **Shooting** ⑤ **Burning** ⑥ **Tingling**

How is your symptom changing?

① **Getting better** ② **Not changing** ③ **Getting worse**



Choose your least and your worst pain rating: O 1 2 3 4 5 6 7 8 9 10

Choose your pain at this moment: O 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with work? 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

How much is your condition interfering with your social activities? 1 2 3 4 5

2nd Condition/Symptom

Describe your symptom: _____When did it start: _____

How did it start: _____

How often do you experience your symptom?

① **constantly** (76-100% of the day)

② **Frequently** (51-75% of the day)

③ **Intermittently** (26-50% of the day)

④ **Occasionally** (0-25% of the day)

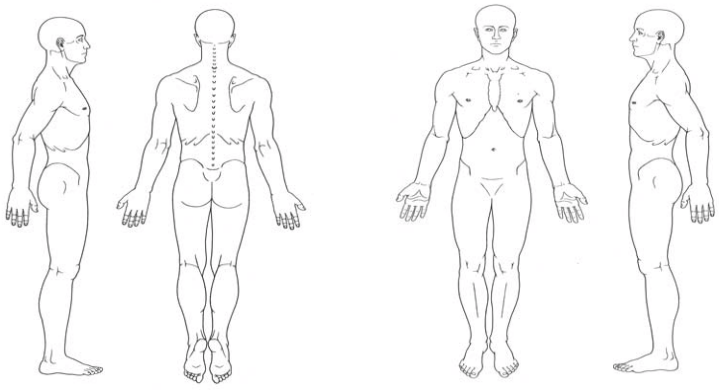
Describe the nature of your symptom:

① **Sharp** ② **Dull ache** ③ **Numb**

④ **Shooting** ⑤ **Burning** ⑥ **Tingling**

How is your symptom changing?

① **Getting better** ② **Not changing** ③ **Getting worse**



Choose your least and your worst pain rating: O 1 2 3 4 5 6 7 8 9 10

Choose your pain at this moment: O 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with work? 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

How much is your condition interfering with your social activities? 1 2 3 4 5

3rd Condition/Symptom: _____

4th Condition/Symptom: _____

5th Condition/Symptom: _____

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Patient Name: _____Date: _____2017

1st Condition/Symptom

Whom have you seen for your symptoms: **NO one Chiropractor MD Physical Therapist Specialist**

What tests have you had for your symptoms: **X-RAYS CT SCAN MRI OTHER**:_____

Do you consider your problem to be severe? **Yes Yes, at times No**

What concerns you most about your condition? _____
_____

What does it prevent you from doing? _____
_____

What alleviates your problem or gives you relief? _____
_____

Have you had similar problems in the past? **YES NO** *Who did you see and when?* _____
_____

2nd Condition/Symptom

Whom have you seen for your symptoms: **NO one Chiropractor MD Physical Therapist Specialist**

What tests have you had for your symptoms: **X-RAYS CT SCAN MRI OTHER**:_____

Do you consider your problem to be severe? **Yes Yes, at times No**

What concerns you most about your condition? _____
_____

What does it prevent you from doing? _____
_____

What alleviates your problem or gives you relief? _____
_____

Have you had similar problems in the past? **YES NO** *Who did you see and when?* _____
_____

In general would you say your overall health right now is: Excellent Very good Good Fair Poor

What is your occupation?

Professional executive	White Collar/Secretarial	Tradesperson	Laborer
Homemaker	FT Student	Retired	Other: _____

If you are not retired, a homemaker, or a student, what is your current work status? Circle

Full-time Self-employed Unemployed Off work Part-time Other

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Patient Name: _____ **Date:** ___/___/2017

What is your : Height_____ Weight _____ Blood Pressure _____

What type of exercise do you do? _____

Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following: List the member/s

□ Rheum Arthritis/Lupus _____ □ Diabetes _____ □ Cancer _____

□ Heart Problems _____ □ Stroke _____ □ Alzheimers _____

Other: _____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight ↑ ↓	□	□	Visual Disturbances
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	Dizziness
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Asthma
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Chronic Sinusitis
□	□	Arthritis	□	□	Hepatitis			**For Females Only**
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Birth Control Pills
□	□	Cancer	□	□	General Fatigue	□	□	Hormonal Replacement
□	□	Tumor	□	□	Muscular Incoordination	□	□	Pregnancy

Other:

_____

List all prescription medications you are currently taking:

_____

List all of the over-the-counter medications you are currently taking:

_____

List all surgical procedures you have had:

_____

What activities do you do at work?

Sit:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day
Stand:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day
Computer work:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day
On the phone:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day
Assembly:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day
Driving:	□ Most of the day	□ Half of the day	□ Some of the day	□ None of the day

What activities do you do outside of work?

_____

Have you ever been hospitalized? No Yes

if yes, why _____

Have you had significant past trauma? No Yes

If yes explain: _____

_____

Anything else pertinent to your visit today?_____