

BROADWAY CHIROPRACTIC WELLNESS CENTER

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

NAME _____ Date: ___/___/2020

COMPLETE ADDRESS _____

DOB ___/___/___ MARITAL STATUS: M S W D # OF CHILDREN ___ RETIRED ___ YES ___

NO

PHONE: home () ___-___-___ work () ___-___-___ cell () ___-___-___

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> BETTER HEALTH | <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> INCREASED ENERGY/FITNESS |
| <input type="checkbox"/> DETOX/CLEANSE PROGRAM | <input type="checkbox"/> MASSAGE THERAPY | <input type="checkbox"/> SAUNA |
| <input type="checkbox"/> WELLNESS PROGRAM | <input type="checkbox"/> CHIROPRACTIC MAINTENANCE PROGRAM | |
| <input type="checkbox"/> NUTRITION PROGRAM | <input type="checkbox"/> 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)

Patient Name: _____ Date: _____ 2020

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:

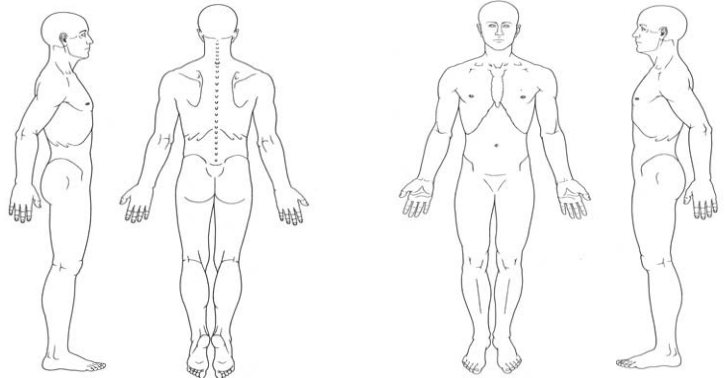
O 1 2 3 4 5 6 7 8 9 10

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:

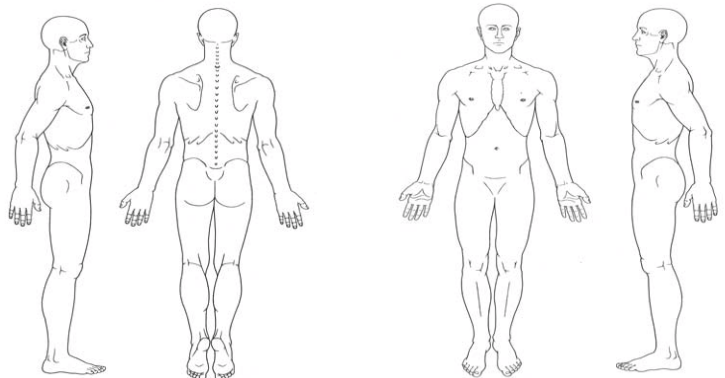
O 1 2 3 4 5 6 7 8 9 10

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: _____

Patient Name: _____ Date: _____ 2020

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*

Patient Name: _____ **Date:** ____/____/2020

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