Welcome to Burpee Family Chiropractic

CONFIDENTIAL

Patient Information

Name_________________________________ Sex: ❑ Female ❑ Male Date__________

Address________________________________City________________State_________Zip___________

Home phone #____________________Cell phone #______________________Birth Date___________

Are you: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer_____________________________________Occupation_____________________________

Do you work: ❑ Full Time ❑ Part Time ❑ Retired Work phone #_____________________

Whom may we thank for referring you?____

Person to contact in case of emergency__________________________Phone #___________________

Symptoms

Reason for visit ____

When did this start?________________What brought this on?_________________________________

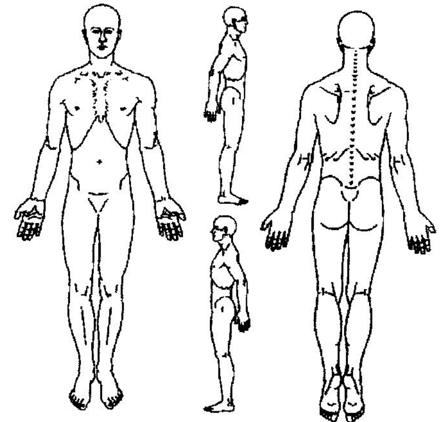
Is this condition getting progressively worse?____

What activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

❑ Other____

Use the letters below to indicate the type and location of your sensations right now on the drawing ➜

A = Ache **B** = Burning **N** = Numbness
P = Pins & Needles **S** = Stabbing **O** = Other



Rate the severity of your pain (1=mild; 10=severe):

Neck:_____________________________

Mid Back:__________________________

Low Back:_________________________

Other:____________________________

_

Is your pain constant or does it come and go?_____________________________

Has this pain occurred before? ❑ No ❑ Yes

Have you seen anyone else for this condition? ❑ No ❑ Yes, if so, please provide the name below:

Name of Doctor ________________________________Treatment type___________________________

Did the treatment help? ____

Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Depression	❑ High Blood Pressure	❑ Pneumonia
❑ Alcoholism	❑ Diabetes	❑ Kidney Disease	❑ Prostate
❑ Anemia	❑ Emphysema	❑ Liver Disease	❑ Prosthesis
❑ Arthritis	❑ Fractures	❑ Measles	❑ Psychiatric
❑ Asthma	❑ Gout	❑ Migraines	❑ Rheumatoid Arthritis
❑ Bleeding Disorders	❑ Heart Disease	❑ Multiple Sclerosis	❑ Stroke
❑ Bronchitis	❑ Hepatitis	❑ Osteoporosis	❑ Tuberculosis
❑ Cancer	❑ Hernia	❑ Pacemaker	❑ Tumors / Growths
❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Ulcers

❑ Other:________________________________

List any surgeries you have had and the dates:____

____

List any bone fractures you have had and the dates:____

____

Medications you currently take (check all that apply):

❑ Pain Killers ❑ Muscle Relaxers ❑ Insulin ❑ Blood Pressure ❑ Blood Thinners

❑ Cholesterol ❑ Cardiac (Heart) ❑ Vitamins / Supplements ❑ Over the counter

❑ Other:________________________________

(*Women*) Are you pregnant? ❑ No ❑ Yes Are you taking birth control pills? ❑ No ❑ Yes

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work):

____

Do you smoke? ❑ No ❑ Yes How much per day?_____________________________________

How much alcohol do you consume on a weekly basis?____

How much coffee or caffeinated beverages do you consume on a daily basis?_______________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Susan M. Burpee, Chiropractor, to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Susan M. Burpee, D.C., Burpee Family Chiropractic, insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

✖____

SIGNATURE OF PATIENT (or Parent if minor) DATE

Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during, the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,______________________________have read and fully understand the above statements. (print name)

All questions regarding the doctor's objectives pertaining to my care in this have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_______________________________ ___________________
(signature) (date)

Consent to evaluate and adjust a minor child

I, _______________________being the parent or legal guardian of ___________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_______________________________ ___________________
(signature) (date)