**DOUYARD CHIROPRACTIC** **DR. AARON W. DOUYARD**

# *WELCOME TO OUR OFFICE*

Welcome! Douyard Chiropractic offers a unique service to our patients and the community. Our efforts are to make your experience here helpful, friendly, and informative. To achieve this, please fill in the information below:

Name:_____

Address:_____ Marital Status: _____

City:_____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Primary Care Doctor: _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Race/Ethnicity:_____ Gender: M F NB

Are you a Student? YES NO if Yes _____ Full Time _____ Part Time

Height:_____ Weight:_____

Reason for consulting Alignment Chiropractic (check all that apply):

_____ I have no special problem. I understand the role of chiropractic health in general health and well being.

_____ I have a disease/symptom (circle one) and I am interested in help for this specific problem. In addition, I am interested in learning about my health potential and the role of chiropractic in improving my family's health.

_____ I have a disease/symptom (circle one) and I am interested in help for this problem, and in learning how to prevent it in the future.

_____ I have a disease/symptom (circle one) and I am ONLY interested in help for this problem.

Previous Chiropractor care:

Who:_____ Where:_____

When:_____ How Long: _____

Today we will determine if we can help you. In order to do that we need the following:

Review your health history, perform an examination and, if necessary, order x-rays.

We will then determine if you are a chiropractic patient.

# CONFIDENTIAL HEALTH INFORMATION

DATE: _____

List any **Allergies**:

❑ Animals ❑ Aspirin ❑ Bees ❑ Chocolate ❑ Dairy ❑ Dust ❑ Eggs ❑ Latex ❑ Molds ❑ Penicillin ❑ Ragweed/Pollen

❑ Rubber ❑ Seasonal Allergies ❑ Shellfish ❑ Soaps ❑ Wheat ❑ X-Ray Dye ❑ Medications: _____

❑ Other: _____

List any **Surgeries:**

❑ Appendix ❑ Back ❑ Brain ❑ Breast ❑ Eye ❑ Elbow ❑ Foot ❑ Gall Bladder ❑ Heart ❑ Hip ❑ Knee ❑ Neck ❑ Neurological ❑ OBGyn

❑ Prostate ❑ Pacemaker ❑ Shoulder ❑ Spine ❑ Tonsils ❑ Thyroid ❑ Wrist ❑ Other: _____

List **ALL Past Medical History** conditions:

❑ Alcoholism ❑ Ankle Pain ❑ Arm Pain ❑ Arthritis ❑ Asthma ❑ Back Pain ❑ Broken Bones ❑ Bursitis ❑ Cancer

❑ Chest Pain ❑ Deafness ❑ Depression ❑ Diabetes ❑ Dizziness ❑ Elbow Pain ❑ Epilepsy ❑ Eye/Vision Problems ❑ Fainting

❑ Fatigue ❑ Foot Pain ❑ Genetic Spinal Condition ❑ Hand Pain ❑ Headaches ❑ Hearing Problems ❑ Hepatitis ❑ High Blood Pressure

❑ Hip Pain ❑ HIV ❑ Jaw Pain ❑ Joint Stiffness ❑ Kidney Stones ❑ Knee Pain ❑ Leg Pain ❑ Menstrual Problems ❑ Mid-Back Pain

❑ Minor Heart Problem ❑ Multiple Sclerosis ❑ Neck Pain ❑ Neurological Problems ❑ Pacemaker ❑ Painful urination ❑ Parkinson's

❑ Polio ❑ Prostate Problems ❑ Shoulder Pain ❑ Significant Weight Change ❑ Spinal Cord Injury ❑ Sprain/Strain

❑ Stroke/Heart Attack ❑ Thyroid ❑ Tingling, numbness ❑ Tuberculosis ❑ Venereal Disease ❑ Other: _____

List **ALL Types of Medications** you are taking:

❑ Anxiety ❑ Muscle Relaxers ❑ Pain Killers ❑ Insulin ❑ Birth Control ❑ Cardiovascular ❑ Allergy ❑ Seizure

❑ Other: _____

List your **Family History**:

❑ Arthritis ❑ Asthma ❑ Back Pain ❑ Cancer ❑ Depression ❑ Diabetes ❑ Epilepsy ❑ Genetic Spinal Condition

❑ High Blood Pressure ❑ Heart Problems ❑ Multiple Sclerosis ❑ Neurological Problems ❑ Parkinson's ❑ Polio

❑ Prostate Problems ❑ Stroke/Heart Attack ❑ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____ _____

_____ _____

Have you had any auto or other accidents? No Yes

Describe: _____

_____

Date of last physical examination: _____ Do you smoke? ❑No ❑Yes Have you ever smoked? ❑ No ❑Yes

Do you drink alcohol? ❑No ❑Yes - How many per day?_____

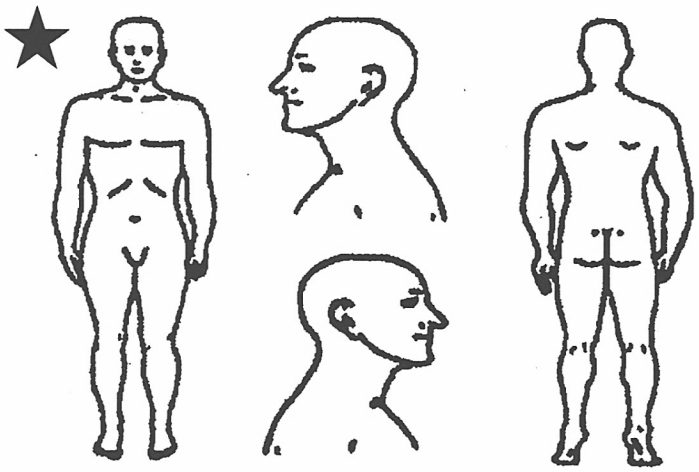
Do you drink caffeine? ❑No ❑Yes - How many per day?_____

Do you excrcise? ❑No ❑Yes (what forms and how often): _____

What is your major complaint?_____ Date problem began:_____

How did this problem begin? (falling, lifting, etc.)?_____

What are your symptoms? ❑Right side ❑Left side ❑Both sides ❑None



PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM

How is your condition changing? ❑GETTING BETTER ❑GETTING WORSE ❑NOT CHANGING

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Describe the intensity of your pain: ❑Minimum ❑Mild ❑Moderate ❑Severe ❑Unbearable ❑No Pain

Describe the nature of your symptoms: ❑ Burning ❑Dull ❑Numb ❑Radiating Pain ❑Sharp ❑Shooting ❑Stabbing ❑Tightness ❑Tingling ❑ Throbbing ❑Ache ❑ Other_____

How often do you experience your symptoms? ❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day) ❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

What are your expectations? ❑ Become pain free ❑ Explanation of my condition ❑ Learn how to care for my condition ❑ Reduce symptoms ❑ Resume normal activity level

What makes your pain better ❑ Acupuncture ❑ Chiropractor ❑ Heat ❑ Ice ❑ Masssge ❑ Nothing ❑ Pain Medication ❑ Physical Therapy ❑ Sleep ❑ Rest ❑ Stretching ❑ Other:_____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What activities aggravate your condition (working, exercise, etc.)?_____

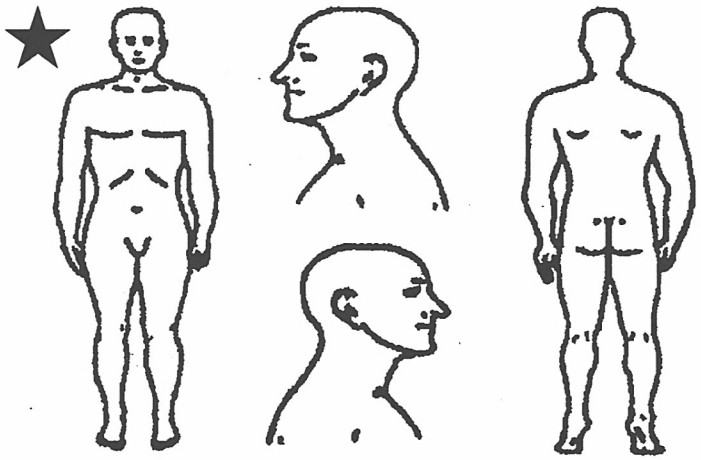
Have you had this condition in the past? ❑YES ❑NO

What makes your pain better (ice, heat, massage, etc.)? _____

What is your SECOND complaint?_____ Date problem began:_____

How did this problem begin? (falling, lifting, etc.)?_____

What are your symptoms? ❑Right side ❑Left side ❑Both sides ❑None



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What activities aggravate your condition (working, exercise, etc.)?_____

Have you had this condition in the past? ❑YES ❑NO

Signature of Patient: _____

Signature of Parent/Guardian (If patient is a minor):_____

Print Name: _____

**DOUYARD CHIROPRACTIC**
**DR. AARON W. DOUYARD**
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**MILL POND PROFESSIONAL BUILDING**
**GLOUCESTER, MA 01930**
**978-282-7400**
**WWW.ALIGNMENTCHIROPRACTICCENTER.COM**

## PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE

Name of person responsible for payment:

_____

I understand and agree that health and accident insurance policies are an arrangement between an isurance carrier and me. Furthermore, I understand that Dr. Aaron Douyard, and any of his duly authorized agents, will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the chiropractic office will be credited to my account. However. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payments. I also understand that is I suspend or terminate my care and treatment, any fees for professional services rendered by the doctor, will be immediately due for payment.

Signature_____ Date_____

Guardian of Spouse _____

### Insurance: ( If you have your insurance card with you, you may leave this section blank)

Name of Insured: _____ Insurance Company:_____

Address:_____

Policy #: _____ Telephone #:_____

**About Dr. Aaron Douyard**

Dr. Douyard received his Doctor of Chiropractic degree in November of 2021 from New York Chiropractic College in Seneca Falls, New York. He also holds a Bachelor of Science degree in Biology from Life University. Dr. Douyard is licensed and board certified to practice chiropractic in the state of Massachusetts. He has extensive training and certifications in multiple chiropractic techniques, spinal and skeletal x-ray study, lower extremity gait analysis and foot orthotics, and soft tissue/trigger point therapy. He is currently in the process of obtaining certifications in SOT (Sacro-Occipital Technique) and VOM(Veterinary Orthopedic Manipulation).

In 2022, he completed a certification through the Titleist Performance Institute(TPI) to assess physical limitations in the body as it relates to the golf swing. By improving mobility and range of motion it greatly reduces the risk of injury, and improves the overall efficiency of each golfers unique swing. As a former PGA of America golf professional, Dr. Douyard has a great deal of experience with golf swing mechanics and common errors. Combining this golf experience with his extensive knowledge of human anatomy and kinesiology, allows him to quickly identify physical limitations, and provide the corrections needed to improve those limitations.

Dr. Douyard is also an avid fisherman and enjoys traveling to participate in numerous freshwater bass tournaments in northeast throughout the fishing season. He is also the Conservation Director for Massachusetts Bass Nation under the national association