Melbourne Chiropractic
Spine and Injury Center

1070 South Wickham Road
Melbourne, FL 32904
Phone#: (321) 499-4608 Fax#: (321) 499-4607

Patient Application

WELCOME

The Doctor and Staff of **Melbourne Chiropractic Spine and Injury Center** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PATIENT IDENTIFICATION

Name: ______________________ **Nickname:** ______________

Address: ______________________

City, State and Zip: ______________________

Male [ ] **Female** [ ] **Marital Status: S M D W Other:** ____________ **DOB:** ____________

Social Security #: ______________________**Age** (Will be kept confidential)**:** ________

Home # :______________________**Cell #:** ______________________

We have the capability to send brief appointment reminders via text **which requires the knowledge of your cell phone carrier. Carrier: ATT Verizon Sprint Cingular Other:** ______________________

Email: ______________________

Occupation:______________________ **Work Phone:** ______________________

Employer:______________________ Ok to call there? Yes [ ] No [ ]

Address: ______________________

City: ______________________**State:** ________ **Zip:** ______________

Contact in case of an emergency, Name: ______________________

Telephone Number:______________________**Relationship:** ______________________

Name of Parent of Minor Patient (If applicable)**:** ______________________

ACCEPTANCE AS PATIENT & PERMISSION TO TREAT/INFORMED CONCENT

I understand and agree that the Dr. Canuel has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment but, are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. Upon acceptance as a patient I authorize Dr. Canuel to proceed with any treatment he deems necessary. I understand that any concerns I may have regarding the risks of chiropractic care will be explained to me by request.

Date:______________________ **Patient Signature:** ______________________

Doctor Signature: ______________________ **Date:** ______________

HEALTH HISTORY CHECK OFF

Check any of the following diseases you have had:

[_] Pneumonia	[_] Mumps	[_] Influenza	[_]Rheumatic Fever	[_] Small Pox	[_] Pleurisy
[_] Polio	[_] Chicken Pox	[_] Arthritis	[_] Tuberculosis	[_] Diabetes	[_] Epilepsy
[_] Measles	[_] Cancer	[_] Mental Disorders	[_] Anemia	[_] Thyroid	[_] Lumbago
[_] Whooping Cough	[_] Heart Disease	[_] Eczema			

Have you been tested HIV Positive? [_] Yes [_] No

Intake:

[_] Coffee [_] Tea [_] Alcohol [_] Cigarettes [_] White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

Musculo-Skeletal:

[_] Low Back Pain	[_] Pain b/w Shoulders	[_] Neck Pain	[_] Arm Pain
[_] Joint Pain/Stiffness	[_] Walking Problems	[_]General Stiffness	[_] Diffult Chewing/Clicking Jaw

Nervous System

[_] Nervous	[_] Numbness	[_] Paralysis	[_] Dizziness	[_] Forgetfulness
[_] Confusion/Depression	[_] Fainting	[_] Convulsions	[_]Stress	[_] Cold/Tingling Extremities

General

[_] Fatigue [_] Allergies [_] Loss of Sleep [_] Fever [_] Headaches

Gastro-Intestinal

[_] Excessive Thirst	[_] Diarrhea	[_] Weight Trouble	[_] Heartburn	[_] Vomiting
[_] Frequent Nausea	[_] Constipation	[_] Colitis	[_] Liver Problems	[_] Hemorrhoids
[_] Poor/Excessive Appetite	[_] Abdominal Cramps	[_] Black/Bloody Stool	[_] Gas/Bloating After Meals	[_] Gall Bladder Problems

Genito-Urinary

[_] Bladder Trouble [_] Discolored Urine [ ] Painful/Excessive Urination

C-V-R

[_] Chest Pain	[_] Short Breath	[_] Varicose Veins	[_] Stroke	[_] Heart Problems
[_] Ankle Swelling	[_] Irregular Heartbeat	[_] Lung Problems/ Congestion	[_] Blood Pressure Problems	[ ] Other

EENT

[_] Ear Aches	[_] Dental Problems	[_] Sore Throat	[_] Vision Problems	[_] Stuffed Nose
[_] Hearing Difficulty				

Female		***Male***	***Either***
[_] Menstrual Irregularity	[_] Vaginal Pain/Infection	[_] Prostate/Sexual Dysfunction	[_] Other Problems ___________________
[_] Menstrual Cramps	[_] Breast Pain/Lumps		

Females Only

Date of last period: ________________________________ _Are you pregnant? [_]Yes [_] No [_] Not Sure

Family History

The following members have same or similar problems as I do:

[_] Mother [_] Father [_] Brother [_] Sister [_] Spouse [_] Child

Date:___________________ **Patient Signature:** ____

ACTIVITIES OF DAILY LIVING

Rate your current difficulties from your accident/illness below. Use the scale 1-5..

Scale:

1= I can do it without any difficulty;
2= I can do it with some pain.
3= I can do it with moderate pain.
4= I can do it but, only with help.
*5= I can **not** do it at all because of pain.*

Please Only Rate Those Activities That You Have Difficulty With.

Difficulties with Self Care and Personal Hygiene Activities:

Bathing [_] Drying Hair [__] Brushing Teeth [__] Putting On Shoes [__] Preparing Meals [__] Taking Out Trash [__]
Showering [__] Combing Hair [__] Making Bed [__]
Tying shoes [__] Eating [__] Doing Laundry [__] Washing Hair [__] Washing Face [__] Putting on Shirt [__]
Putting on Pants [__] Cleaning Dishes [__] Going to Toilet [__]

Difficulties with Physical Activities:

Standing [__] Walking [__] Kneeling [__] Bending Back [__] Twisting left [__] Leaning back [__]
Sitting [__] Stooping [__] Reaching [__]
Bending Left [__] Twisting Right [__] Leaning Left [__] Reclining [__] Squatting [__] Bending Forward [__]
Bending Right [__] Leaning Forward [__] Leaning Right [__] Standing for Long Periods [__] Sitting for Long Periods [__] Kneeling for Long Periods [__]

Difficulties with Functional Activities:

Carrying small objects [__] Lifting weights off floor [__] Pushing things while seated [__] Exercising upper body [__]
Carrying large objects [__] Lifting weights off table [__] Exercising lower body [__]
Pushing things while standing __] Exercising Lower Body [__] Carrying Brief Case [__] Climbing Stairs [__]
Pulling Things While Seated [__] Exercising Arms [__] Carrying Large Purse [__] Climbing Inclines [__]
Pulling Things While Standing [__] Exercising Legs [__]

Difficulties with Social/Recreational Activities:

Bowling [__] Jogging [__] Swimming [__] Ice Skating [__] Competitive Sports [__] Dating [__]
Golfing [__] Dancing [__] Skiing [__] Roller Skating [__] Hobbies [__] Dining Out [__]

Difficulties with Traveling:

Driving a motor vehicle [__] Riding as a passenger in a car [__] Riding as a passenger on a train [__]
Driving for long periods of time [__] Riding as a passenger on an airplane [__] Riding as a passenger for long periods [__]

Difficulties with Different Forms of Communication:

Concentrating [__] Hearing [__] Listening [__] Speaking [__] Reading [__] Writing [__] Using a Keyboard [__]

Difficulties with Senses:

Seeing [__] Hearing [__] Sense of Touch [__] Sense of Taste [__] Sense of Smell [__]

Difficulties with Hand Function:

Grasping [__] Holding [__] Pinching [__] Percussive Movements [__] Sensory Discrimination [__]

Difficulties with Sleep:

Being able to have normal, restful sleep [__]

Write in any additional information regarding your Activities of Daily Living (not covered above): ______________________________

____

____

Any other prior symptom history, not covered above, you feel we should know:

____

____

Patient Signature:______________________ Date:______________________

PRESCRIPTIONS/MEDICATIONS

What prescription medication(s) are you taking if any?

[ ] High Blood Pressure [ ] Blood Thinners
[ ] Other [ ] List Allergies or Adverse Reactions to Medications

Are you taking any over the counter medications/drugs or supplements? Yes [ ] No [ ]

FAMILY PHYSICIAN

Who is your family physician? : ______________________ Phone #: ______________________

Address: ______________________City: ______________________

State: ______________**Zip:** ______________ Specialty:______________________

OTHER PHYSICIANS

Are you seeing any other doctor now for any reason? Yes [ ] No [ ] Dr.: ______________________

For what purpose?: ______________________ Phone#: ______________________

I authorize Canuel Chiropractic and Wellness to send my chiropractic records to my physician(s) in an effort to keep them informed of my chiropractic health and well being.

SOCIAL HISTORY

Smoker: Yes [ ] No [ ] If yes, how many packs? ______________________
Alcohol Yes [ ] No [ ] If yes, how much? ______________________

PAIN CHART

Please circle the pain scales below to note the pain you feel with this condition. (1=Mild) to **ten** (10=Very Severe)

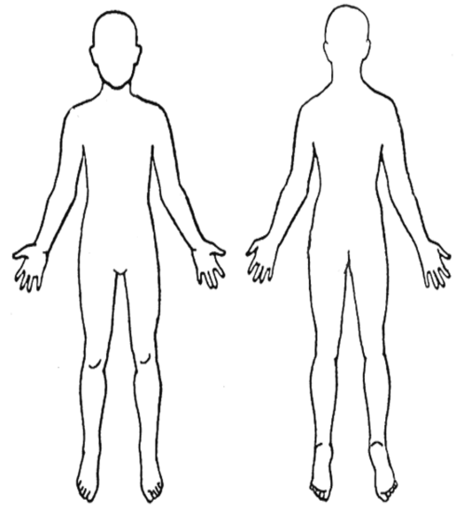
0 1 2 3 4 5 6 7 8 9 10
Neck / Shoulder / Arm Pain

0 1 2 3 4 5 6 7 8 9 10
Mid Back Pain

0 1 2 3 4 5 6 7 8 9 10
Low Back / Leg Pain

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

If you are in pain, please mark the exact location of your pain on the diagram below.



PLEASE LIST BELOW ANY CONDITION YOU ARE BEING TREATED FOR OR EXPERIENCING.

Also, describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: dull, sharp, consistent, off & on, when standing, when sitting, when trying to sleep, etc.

Major Complaints: ______________________

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____

Patient Signature:______________________ Date:______________________

INSURANCE INFORMATION

Is your visit today the result of an accident either work or auto related? This information is important to advise as there may be additional or substitute paperwork you would be required to fill out usually either at the request of your insurance company or employer. [ ] Yes [ ] No **Auto Accident [ ]** **Work Accident [ ]**

INSURANCE TYPE AND PAYMENTS OF BENEFITS:

Please file the following insurance for me. The insurance information can be obtained from copy of my card(s):

Major Medical/Health (Primary): ____

Major Medical/Health (Secondary): ____

Medicare: [ ]Primary [ ] Secondary

This office will process your insurance forms (if applicable) upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

__________ Initial Here

I assign directly to Canuel Chiropractic & Wellness Center all payment of medical benefits, if any, otherwise payable to me for services rendered but, not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

HIPPA: ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

__________ Initial Here

I hereby acknowledge that Canuel Chiropractic and Wellness Center has a written copy of their notice of privacy practices for my review. I understand that I may ask for a copy for my records at this time or that I may view them in it entirety at anytime on their website. At this time I do not wish to receive a hard copy in an effort to help the environment.

__________ Initial Here

You may discuss my HIPPA-Protected information with the following person(s). In understand that if they are not listed here Canuel Chiropractic and Wellness can not provide them any information regarding my appointments. (This includes knowledge if I am in the office, have been there or are on the way in).

Please Print Name	Relationship

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Canuel Chiropractic and Wellness Center I have both rights and responsibilities.

My Rights: I have the right to be respected and supported. I have the right to be informed about and involved in all aspects of my healthcare. I have the right to complete confidentiality regarding my medical records. I have the right to care that is considerate and respectful of my personal beliefs and values.

My Responsibilities:

1. I have the responsibility to report all of my significant health-related conditions that may be relevant to the ability of Canuel Chiropractic & Wellness Center providers to provide effective patient care.
2. I have the responsibility to accurately report to Canuel Chiropractic & Wellness Center my insurance information and any future changes.
3. I have the responsibility to attend all scheduled appointments and comply with all treatments, referrals and follow-up recommendations of my health care providers.
4. I have the responsibility to behave appropriately towards all staff members. Inappropriate behavior includes, but is not limited to, 1) arriving for your appointment under the influence of alcohol or drugs and, 2) being verbally abusive to staff or others in the facility.
5. I have the responsibility to notify my healthcare providers of any changes in my condition that may necessitate a change in my treatment plan.

I have read and fully understand all of above (this page) & agree to comply with these requirements.

Patient Name	Date