Melbourne Chiropractic
Spine and Injury Center

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

Stephen H. Canuel, D.C.
Patient Demographics

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:** _____

Last 4 of your Social Security #: _____ **Mother's Maiden Name (For Your Security):** _____

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.

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

Patient Intake

PATIENT NAME: _____ ***DATE:*** _____

HEALTH HISTORY

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years **Illicit drugs:** ___ Yes ___ No

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:
Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Medical Implants: _____ **Medical alerts: _____**
Surgical Implants: _____ **Pregnancy: yes ___ no ___**

List any history of pre-existing illnesses including cancer, childhood diseases and allergies (include approximately last date of treatment)_____
_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST:

Constitutional-last six months
□ Weight loss □ Chills
□ Fever □ Weakness/fatigue

HEENT
□ Visual Loss □ Blurred/double vision □ yellow sclera
□ hearing loss □ sneezing □ nasal congestion □ runny nose
□ sore throat □ other

Skin
□ rash □ itching □ cancer □ other

Respiratory
□ shortness of breath □ cough □ sputum □ COPD □ emphysema
□ asthma □ pneumonia □ sleep apnea □ Tuberculosis □ other

Cardiovascular
□ chest pain / angina
□ heart attack, myocardial infarction
□ congestive heart failure
□ other: _____
□ high blood pressure
□ heart murmur, valve disorder
□ mitral valve prolapse
□ bleeding problems
□ irregular heartbeat, arrhythmia
□ peripheral vascular disease
□ deep vein thrombosis

Gastrointestinal Disorders
□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____ □ anorexia □ Constipation
□ acid reflux, GERD, heartburn □ irritable bowel □ liver disease □ `
□ GI bleed □ inflammatory bowel disease □Abdominal Cramps □Poor/Excessive Appetite
□ Black/Bloody Stool □ other: _____

Genitourinary Disorders
□ urinary tract infection □kidney problems □dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Hematologic
□ anemia □ bleeding □ bruising □ other

Neurologic Disorders
□ stroke or TIA □ Parkinson's □ cerebral palsy □polio □headaches □ paralysis □ dizziness □headaches
□ peripheral neuropathy □ MS □ polio □Confusion/depression □ convulsions □ Fainting □ other: _____

Bone & Joint Disorders
□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Lymphatic
□ enlarged lymph nodes □ splenectomy □ other

Psychiatric
□ depression □ anxiety □ other

Endocrine
□ excessive sweating □ temperature intolerance □ excessive thirst
□ excessive urination □ other

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____
Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Family History

The following members have same or similar problems as I do:
□ Mother □ Father □ Brother □ Sister □ Spouse □ Child

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.

PAIN CHART

Please circle the pain scales below to note the pain you feel with this condition. (1=Mild) to **ten** (10=Very Severe)
Top Graph – Rate your pain when it's at it's LEAST
Bottom Graph – Rate your pain when it's at it's WORST

L 0 1 2 3 4 5 6 7 8 9 10
W 0 1 2 3 4 5 6 7 8 9 10

Neck / Shoulder / Arm Pain

L 0 1 2 3 4 5 6 7 8 9 10
W 0 1 2 3 4 5 6 7 8 9 10

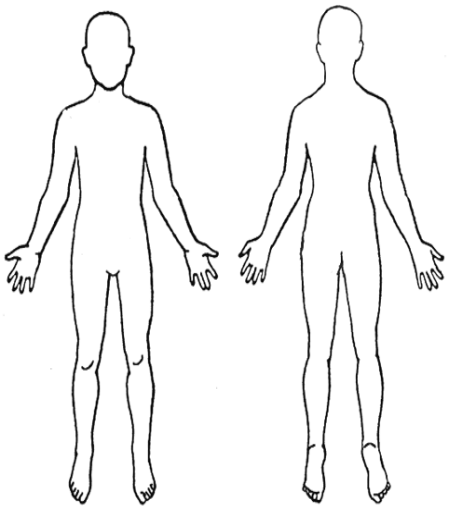
Mid Back Pain

L 0 1 2 3 4 5 6 7 8 9 10
W 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: _____

_____

_____

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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. 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

_____ 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. I will call if I am unable to make an appointment.
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