Melbourne Chiropractic
Spine and Injury Center

1st Centre Building
490 Centre Lake Drive NE, Suite 100A
Palm Bay, FL 32907
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

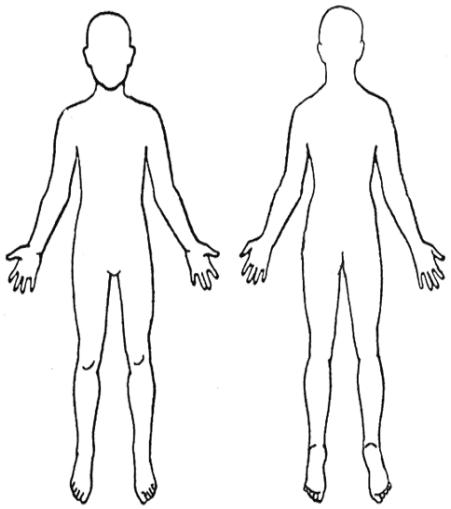
Mid Back Pain

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

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2021

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns, and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but, serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 out of every 100,000 people, whether they are receiving health care of not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that is tis not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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

Because there is more information than there is time we would like to invite you to sign up for our Chiropractic Monthly E-Newsletter:
Receive Valuable Health Tips, Articles, Research, Some Healthy Recipes and More.

Name (Please Print): _____

Preferred Nickname if applicable (e.g. Robert may prefer Bob): _____

Date of Birth: _____

Email Address: _____

Signature: _____

Privacy Policy: Your email address and personal information is and always will be kept confidential.

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MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address: _____
   _____
2. Phone Number: _____
3. Please describe the collision in your own words:
   _____
   _____
4. Where did the collision occur? City/Town: _____ State: _____
5. Date of collision: _____ Time: _____ AM PM
6. Were you the: □driver □passenger □pedestrian
   a. If passenger, were you in the □front seat □right rear seat □left rear seat
7. What type of vehicle were you in? _____
8. What type was the other vehicle? _____
9. Did your vehicle strike the other vehicle? □yes □no
10. Was your car struck by the other vehicle? □yes □no
11. Was the impact from: □the front □the rear □the left side □the right side
12. Was your vehicle shoved: □forward □backward □sideways
13. Were you shoved: □forward □whipped backward
14. Did your seat have a head restraint (headrest?) □yes □no □ I Don't Know
    a. If yes, what was the position □low □mid-position □high □I Don't Know
15. Did your hat/glasses end up in the back seat or rear window? □yes □no
16. Did any other part of your body hit the interior of the vehicle? □yes □no
    a. If yes, please specify: □seatbelt restraints □steering wheel
       □dashboard □windshield □side door □side window □other _____
    b. Which part of your body? □chest □head □chin □face □R/L knee
       □R/L shoulder □R/L hand □other _____
17. Were you holding on to the steering wheel? □yes □no
18. Did you brace your arms against the dash? □yes □no
19. Did you brace your legs against the floorboard? □yes □no
20. Did the vehicle go into a spin or roll as a result of the impact? □yes □no
    a. If yes, explain: _____
21. How much damage was there to the outside of the vehicle? □none □some □a lot
22. How much damage was there to the inside of the vehicle? □none □some □a lot
23. At the point of impact, where did you experience pain? Be specific:
    _____
24. Immediately after the accident were you: □conscious □dazed □unconscious
    a. If you lost consciousness, for how long? _____
25. Were you wearing a seat belt? □yes □no

26. Did the belt have a shoulder harness? □yes □no
27. At the time of impact were you: □looking straight ahead □looking to the right □looking to the left □looking down □looking up
28. Did the seat break as a result of the impact? □yes □no
29. Were you braced for the impact? □yes □no
30. Were you aware of the impending crash or surprised by the impact? □yes □no
31. Did you go to the hospital/acute care clinic? □yes □no
    a. If yes, when? □right after the accident □next day □other_____
    b. If yes, how did you get there? □ambulance □other: _____
32. If by ambulance, did the ambulance attendants place you in a: □neck brace □back brace □other _____
    a. Any medication or medical supplies given? _____
33. If you went to the hospital, please answer the following:
    Name of hospital _____
    Treatment Received _____
34. Did you have x-rays taken at the hospital? □yes □no
35. Have you had any similar problems before? □yes □no
    a. If yes, explain: _____
36. Do you have arthritis or degenerative joint disease? □yes □no
37. What type of work do you do? _____
38. What are your job requirements? _____
39. Have you lost any days of work from this injury? □yes □no
    a. If yes, give dates: _____
40. Is it difficult to work since the accident? □yes □no
41. Do you notice any of your **HOME** activities that are different **now** than they were **before** the injury? □yes □no

Print Name _____

Patient Signature _____ Date _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.