Melbourne Chiropractic
Spine and Injury Center
David M. Durkin, D.C.

1st Centre Building
490 Centre Lake Drive NE, Suite 100A
Palm Bay, FL 32907
Phone#: (321) 499 - 4608 Fax#: (321) 499 - 4607

WELCOME

The 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: _____ **Preferred Name:** _____

Address: _____

City, State and Zip: _____

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

Last 4 of your SS #: _____ **Mother's Maiden Name (Security Question):**_____

Cell #:_____ **Home #:** _____

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 CONSENT

I understand and agree that Dr. Durkin 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. Durkin 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

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 THAT YOU HAVE HAD IN 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 prolapses
□ 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.: _____

Purpose? _____ Phone#: _____

I authorize Melbourne Chiropractic Spine & Injury Center to send my chiropractic records to my physician(s) 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 its WORST

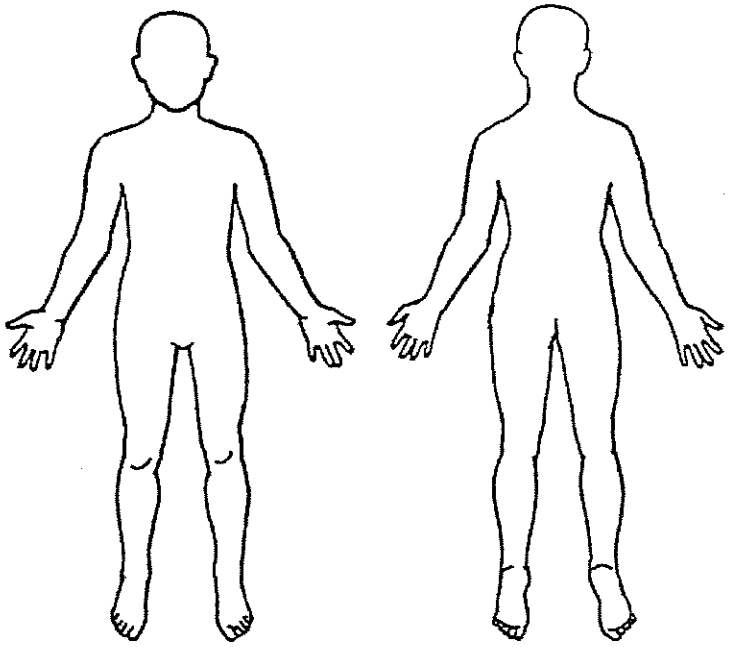
L 0 1 2 3 4 5 6 7 8 9 10
W 0 1 2 3 4 5 6 7 8 9 10
Neck / Shoulder / Arm Pain

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

Please mark the exact location of your pain below.

FRONT **BACK**



When did your pain begin?_____.

How would you describe your pain? *Mark all that apply*

[ ] Dull [ ] Sharp/Stabbing [ ] Achy [ ] Throbbing [ ] Radiating [ ] Burning [ ] Numbness

Describe the frequency. Is it [ ] **constant** or [ ] **intermittent**?

Anything else? _____

Activities of Daily Living

*If you have **more than one complaint**, please **answer each question for each individual complaint and indicate** the score for each complaint. Please use the graph below to indicate your pain level right now, on average, and when it's at its best and worst.*

What is your pain level **RIGHT NOW?**

No Pain_____Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

What is your **AVERAGE** pain level?

No Pain_____Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

What is your pain **at its BEST?**

No Pain_____Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

What is your pain **at its WORST?**

No Pain_____Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life such as:

Carry Groceries/Kids	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Comp Use	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform

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.

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 best 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 by your insurance for any reason, you will be responsible for making payment in full.

_____
Initial Here

I assign directly to Melbourne Chiropractic Spine & Injury 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 Melbourne Chiropractic Spine & Injury 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 at anytime on their website. Currently, I do not wish to receive a hard copy in an effort to help reduce paper for the environment.

_____
Initial Here

You may discuss my HIPPA-Protected information with the following person(s). I understand that if they are not listed here Melbourne Chiropractic Spine & Injury 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 Melbourne Chiropractic Spine & Injury 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 the above (this page) & agree to comply with these requirements.

_____ _____
Patient Signature Date

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

2023

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 in 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 1.7 out of every 100,000 people, whether they are receiving health care or 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: _____

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

Motor Vehicle Collision Questionnaire

Please answer all questions to the best of your ability.

Name:_____ DOB:_____ Date:_____

1. Please describe the collision in your own words.

_____

_____

_____

2. Where did the collision occur? City:_____ State:_____
3. Date and approximate time of collision:_____
4. Were you the [ ] driver [ ] passenger [ ] pedestrian [ ] cyclist
   a. If passenger, were you the [ ] front seat [ ] rear left seat [ ] rear right seat [ ] middle seat?
5. What type of vehicle were you in?_____
6. What type was the other vehicle?_____
7. Was your car struck by the other vehicle? [ ] yes [ ] no
   a. If no, did your vehicle strike the other vehicle? [ ] yes [ ] no
   b. If no, please explain._____
8. Approximately how fast were you traveling?_____
9. Approximately how fast was the other vehicle traveling?_____
10. Was your vehicle struck in the [ ] front [ ] side [ ] rear
    a. Front [ ] center [ ] left front [ ] right front
    b. Side [ ] left front [ ] left rear [ ] left center [ ] right front [ ] left rear [ ] left center
    c. Rear [ ] center [ ] left rear [ ] right rear
11. Was your vehicle moved [ ] forward [ ] backward [ ] sideways?
12. Were you whipped [ ] forward [ ] backward?
13. Did your seat have a headrest? [ ] yes [ ] no [ ] I don't know.
    a. If yes, what was the position? [ ] low [ ] middle [ ] high [ ] I don't know.
14. Did your hat/glasses end up in the back seat or rear window? [ ] yes [ ] no [ ] n/a
15. Did any other part of your body hit the inside of the car? [ ] yes [ ] no
    a. If yes, please specify:_____
    (EXAMPLE: My knee hit the front dashboard.)
16. Were you holding onto the steering wheel? [ ] yes [ ] no [ ] n/a
17. Did you brace yourself against the dash or seat in front of you? [ ] yes [ ] no [ ] n/a
18. Did you brace yourself against the floorboard? [ ] yes [ ] no [ ] n/a
19. Did the vehicle go into a spin or roll due to the collision? [ ] yes, spin [ ] yes, roll [ ] no
20. How much damage was there to the outside of your vehicle?_____
21. How much damage was there to the inside of your vehicle?_____
22. At the point of impact, where did you experience pain? Be specific:_____

    _____
23. Immediately after the accident, did you lose consciousness? [ ] yes [ ] no

a. If yes, for approximately how long?_____
b. If no, were you dazed/confused?_____

24. Were you wearing a seatbelt? [ ] yes [ ] no
25. At the time of impact which direction were you looking? [ ] forward [ ] right [ ] left [ ] up [ ] down
26. Were you aware of the impending crash? [ ] yes [ ] no, I was surprised
27. Were you braced for the impact? [ ] yes [ ] no
28. Did you go to a hospital or urgent care? [ ] yes [ ] no
    a. If yes, did you go immediately or in the days after? _____
    b. If yes, how did you get there? [ ] ambulance [ ] other:_____
    c. If by ambulance, were you placed in a [ ] neck brace [ ] back brace [ ] or other:_____
29. Did you have imaging taken at the hospital? [ ] yes [ ] no Specify:_____
30. What type of work do you do?_____
31. Have you lost any days of work due to this accident? [ ] yes [ ] no
32. Has this impacted your daily life? [ ] yes [ ] no
    a. If yes, in what ways:_____

Print name:_____
Signature:_____ Date:_____