New Patient Health History Form

In order to provide you the best possible care, please complete this form.

Patient Information

First Name: _____ Last Name: _____ Todays Date: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

[ ] Billing address same as Mailing Address

Phone Number: _____ [ ]Cell [ ] Home Work Number: _____

E-Mail* _____

Your E-Mail will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Referred By: _____

Occupation: _____ Employer: _____

Marital Status: _____

Emergency Contact: _____ Relation: _____

Phone Number: _____

Current Complaints

Nature of Injury: [ ] Automobile* [ ] Work [ ] Other
Date of Injury: _____ Date symptoms appeared: _____
Please Describe: _____
_____

Have you ever had the same condition? [ ] Yes [ ] No If yes, When? _____
Seen anyone for this injury/condition? If so list names: _____
Have you ever been under Chiropractic Care? [ ] Yes [ ] No
If yes, please describe: _____ Where? _____

Signature

Name of Insured (printed): _____

*I understand and agree that health/accident Insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian/Authorized representative Signature: _____ Date: _____

Medical History

Have you been treated for any conditions in the last year? [ ] Yes [ ] No
If yes, please describe: _____

_____

Date of last physical exam: _____ Is there any chance you are pregnant? [ ] Yes [ ] No
Have you had x-rays taken? [ ]Yes [ ] No If yes, Where? _____
What medications are you currently taking and for what? (Please list dosage and amounts, frequency, ect.)
(Please include all Vitamins, minerals, and herbs you are taking and for what?)

_____
_____
_____
_____
_____

Have you ever

Broken bones?	[ ]No [ ] Yes	Explain if yes:_____
Been hospitalized?	[ ]No [ ] Yes	Explain if yes:_____
Been in an auto accident?	[ ]No [ ] Yes	Explain if yes:_____
Had Sprains/Strains?	[ ]No [ ] Yes	Explain if yes:_____
Been struck unconscious?	[ ]No [ ] Yes	Explain if yes:_____
Had surgery?	[ ]No [ ] Yes	Explain if yes:_____

_____
_____

Family History

Family Members- Present and past health conditions (Example: Heart Disease, Cancer, Diabetes, Arthritis, ect.)

_____
_____
_____
_____

Do you experience pain every day?	[ ]No [ ] Yes
Do your symptoms interfere with daily life?	[ ]No [ ] Yes
Does pain wake you up at night?	[ ]No [ ] Yes
Are your symptoms worse during certain times of the day?	[ ]No [ ] Yes
Do changes in weather affect your symptoms?	[ ]No [ ] Yes

What activities aggravate your symptoms?

_____
_____

Comments:

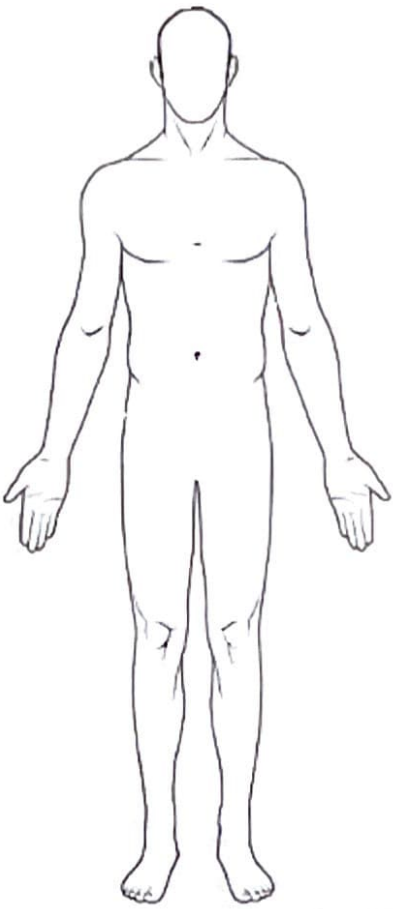
_____
_____
_____

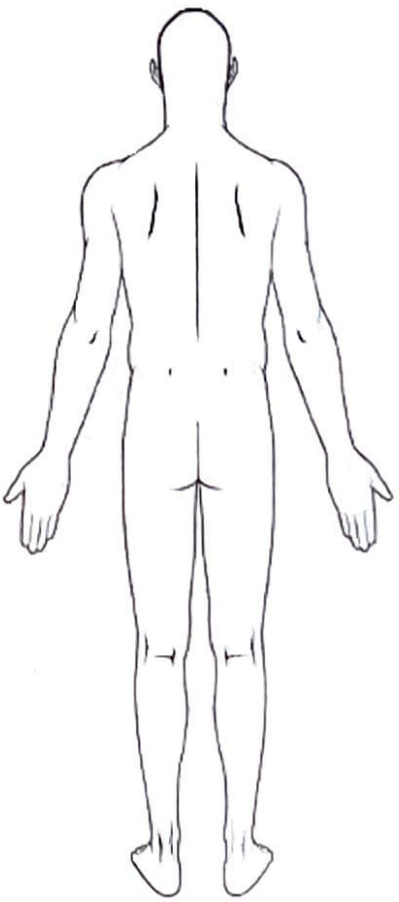
Have you ever suffered from:

[ ] Alcoholism
[ ] Allergies
[ ] Anemia
[ ] Anxiety
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Asthma
[ ] Back Pain
[ ] Breast Lumps
[ ] Bronchitis
[ ] Bruise Easily
[ ] Cancer
[ ] Chest Pain/Conditions
[ ] Cold Extremities
[ ] Constipation
[ ] Cramps
[ ] Depression
[ ] Diabetes
[ ] Digestion Problems
[ ] Dizziness
[ ] Ears Ringing
[ ] Excessive Menstruation
[ ] Eye Pain or Difficulties
[ ] Fatigue
[ ] Frequent Urination
[ ] Headache
[ ] Hemorrhoids
[ ] High Blood Pressure
[ ] Hot Flashes
[ ] Irregular Heart Beat
[ ] Irregular cycle
[ ] Kidney Infection
[ ] Kidney Stones
[ ] Loss of Memory
[ ] Loss of Balance
[ ] Loss of Smell
[ ] Loss of Taste
[ ] Neck Pain or Stiffness
[ ] Nervousness
[ ] Nosebleeds
[ ] Pacemaker
[ ] Poor Posture
[ ] Prostate Trouble
[ ] Sciatica
[ ] Shortness of breath
[ ] Sinus Infection
[ ] Sleep Problems or Insomnia
[ ] Spinal Curvature
[ ] Stroke
[ ] Swelling of Joints
[ ] Thyroid Conditions
[ ] Tuberculosis
[ ] Ulcers
[ ] Varicose Veins
[ ] Venereal Disease
[ ] Other: _____

Please use the following letters to indicate TYPE and LOCATION of the Symptoms you currently are experiencing.

A= Ache
B= Burning
N=Numbness
P= Pins and Needles
S= Stabbing
O= Other





Guardian Chiropractic, LLC
Dr. Amanda Angell, DC
972 Western Avenue
Manchester, Maine 04351
Telephone: (207) 622-3900
Fax: (207) 622-1960

Financial Policy

It is our office policy that all services rendered are charged directly to you the patient and that you are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment.

Once an appointment has been made, it is reserved specifically for you. If you are unable to keep your appointment, please give a 24-hour notice to allow us to accommodate waiting patients, there will be a $25 fee for missed appointments.

If you would like a call reminder the day before, our staff is happy to do so upon request.

Insurance Policy

It is the policy of this office to extend our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under chiropractic care.

- The privilege of insurance assignment begins when your insurance forms are received by our office.
- All deductible payments MUST be made prior to insurance submittal.
- All co-payments are payable when service is rendered. (Co-payment is that part of service that is not paid by your insurance) A $200 co-payment balance must not be exceeded by any patient or professional care may be terminated.
- Since we do not own your policy and since from time to time, we experience difficulty in collecting from your insurance company and since insurance assignment is a privilege it may be terminated at any time. Of course, we will give you ample notice and ask that you act in your own behalf with your insurance company.
- This office does not promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.
- When making a health care decision it is important to remember that you the patient are ultimately financially responsible for any services rendered.
- Lastly, it is our goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your healthcare or any of our policies, please let us know.

Signature _____

Printed Name _____ Date_____

Informed Consent to Chiropractic Treatment

Please read this consent form and discuss it, if you would like to, with Dr. Angell, and then sign where indicated at the bottom of the page. Clinicians who use spinal manual therapy techniques, such as joint manipulation, mobilization, or adjustment are required to inform their patients that there may be some risks associated with such treatment.

Treatments provided at Guardian Chiropractic, LLC, including the spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, for headaches and other neuromusculoskeletal symptoms. Treatment provided at Guardian Chiropractic, LLC very possibly also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many standard medical treatments given for the same forms of musculoskeletal pain, such as muscle relaxing drugs, anti-inflammatory drugs such as aspirin, or pain pills. The most frequent risk that occurs in a chiropractic clinic is from burns associated with hot packs. Our office does NOT use hot packs. Rarely some patients have reported muscle or ligament sprains or strains or rib fractures following an adjustment, however, our low amplitude techniques make that extremely improbable. There have been some "reports" of disc injury following an adjustment, however, there is NO scientific study that has ever demonstrated that such injuries are caused, or may be caused, by adjustments or manipulative techniques. In fact there is much scientific evidence to the contrary. Chiropractic adjustments offer disc patients significant relief and a speedier recovery without the need to resort to surgery. There have also been "reports" of injuries to a vertebral artery following neck adjustments. Usually these patients have a predilection for vertebral artery dissection prior to their chiropractic visit. These patients are already at risk for stroke under many positional activities. They are already at risk for serious neurological injury and impairment, and are no more likely to have such an incident in a chiropractic office than they are in a medical clinic or a beauty salon. This form of complication is astronomically rare occurring about 1 in 12–50 million and has little or no correlation with the chiropractic adjustment.

Dr. Angell will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for outside consultation and/or further medical evaluation if deemed necessary.

Acknowledgement: I acknowledge that I have read, discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment/treatments offered or recommended to me by Dr. Angell, including joint adjustments or manipulations or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulders, upper limbs and lower limbs), including various modes of physical therapy, and if necessary, diagnostic x-rays. I intend this consent to apply to all my present and future treatments at Guardian Chiropractic, LLC.

Patient Signature: _____

Printed Name: _____

Date:_____

Guardian/Translator (print):_____

Name:	Date:

Exam Type: New Patient New Injury Return to care

Supine	L	R
Lindner		
SLR		
Braggards		
WLR		
Fabere Pat.		
Psoas 4/5		
TFL 4/5		
Hip Flex (L1-3)		
Ft. Eversion (S1)		
Piriformis 4/5		
Leg Ext. (L2-4)		
Hip Abduction (L4)		
Hip Abduction (L5)		
Hip Abd. w/ I/E Rot		
Supraspinatus 4/5		
Triceps w/Ext. 4/5		
Triceps w/Flex 4/5		
Brachioradalis		

Sitting	L	R
Val + Bech		
Shoulder Deep		
Wrights		
Supraspin 4/5		
Infraspin 4/5		
Maximum Cervical Depression		
Subcapularis 4/5		
Shldr Abd. (C5)		
Wrist Ext (C6)		
Wrist Flex (C7)		
Finger Flex (C8)		
Finger Abd (C7, T1)		
Wrist Pron. 4/5		
Abd. Poll. Brev. 4/5		

Vitals	
Weight	
Wears orthotics	
Heel Lift	
Blood Pressure	RT
Pulse	RT

Prone	L	R
Hibbs		
Yeomans		
Hip Ext 4/5		

Posture	L	R
Head Tilt		
Head Rot.		
Shoulder (high)		
Shoulder (ant)		
Iliac Crest (high)		
Pronation		
Foot Flare		
Knee Huperext		
Minors		
Adams		
Antalgia		
Kemps		
Toe Walk (S1)		
Heel Walk (L5)		

Reflexes	L	R
Biceps (C5)		
Triceps (C7)		
Brach (C6)		
Patellar (L4)		
Achilles (S1)		
Plantar		

Myospasms/Myofacitis	L	R
Subocc.		
Trap		
Scalenes		
SCM		
Lev. Scap		
Rhom		
Quad Lumb		
Piriformis		
TFL		
Erector Sp. T/S		
Erector Sp. L/S		
Pects		
Infraspinatus		
Supraspinatus		

Hip Motion	N	L	R
Flex.	120		
Ext.	30		
Int. Rot.	40		
Ext. Rot.	40		

Shoulder Motion	N	L	R
Flex	180		
Int. Rot.	90		
Ext. Rot.	90		
Abd.	180		

Cervical Motion	N	EX
Flex	60	
Ext	50	
R Lat Flex	40	
L Lat Flex	40	
R Rot	80	
L Rot	80	

Dermatone	L	R
C5		
C6		
C7		
C8		
T1		
L1		
L2		
L3		
L4		
L5		
S1		

Dorso-Lumbar Motion	N	EX
Flex	60	
Ext	50	
R Lat Flex	40	
L Lat Flex	40	
R Rot	80	
L Rot	80	

Extremity Subluxation		
TMJ		
SC/AC/GH		
Radius		
Ulna		
Carpals		
Thumb		
Talus		
Feet		
Med Tibia		
Lat Tibia		

Subluxations		
OCC		
C1		
C2		
C3		
C4		
C5		
C6		
C7		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
SI Flex		
SI Ext		
PI Ilium		
AS Ilium		
PD		