Date _____

Welcome to Brookside Chiropractic

Please take a few minutes to fill in your information.

Name _____ SSN #_____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Height _____ Weight _____Age _____

Cell Phone # (____) – ____ - _____ E-mail address:_____

Job Profession _____

Do you have children? Yes or No If so, how many? _____

Who may we thank for referring you to Brookside Chiropractic?

_____

In an emergency, whom do we contact?

Name _____ Relation _____

Phone # _____

What are your primary goals in coming to Brookside Chiropractic?

1. _____

2. _____

Have you previously been to a *chiropractor*? ***Yes*** *or* ***No***

Approximate date of last visit? _____

Who is your *Primary Care Physician*? _____

Approximate Date of last medical exam: _____

Have you had X-rays, MRI, or CT scan in the past 6 months? **Yes** or **No**

When was your last auto accident? _____

Current Prescription Medications or Over-The Counter Medications:

Medication:_____Reason for taking:_____ How Long?_____

Medication: _____Reason for taking:_____How Long?_____

Medication:_____Reason for taking:_____How Long?_____

Please list all ***vitamins or supplements*** you are presently taking:

_____

_____

Health Concerns In Order of Severity	*Severity on a scale of 1-10*	*When did the episode begin?*	*If you had the condition before, when?*	*Did the problem begin with an injury?*	*Are symptoms constant? Or on and off?*

List any major ***traumas***, car accidents, falls, and/or injuries along with approximate dates:

_____

List any major ***diseases*** along with approximate dates:

_____

List any major ***surgeries*** along with approximate dates:

_____

Please mark the following as they apply to you:

	Daily	Weekly	Monthly	Never
Alcohol				
Soft Drinks, Energy Drinks, Caffeinated Drinks				
Dairy (ice cream, cheese, milk, yogurt)				
Grains (Bread, pasta, cereal, other)				
Water				
Processed or Fast-Food				
Meat (beef, pork, fish, chicken, etc)				

Do you ***Exercise*** on a regular basis? _____ If so, how many days per week? _____

Do you view your Health as an investment or an expense? _____

How committed are you to living a healthier life

on a scale of 1 to 10 (with 10 = healthiest life possible) ? _____

Please mark any of the following conditions that currently or have previously affected you:

GENERAL	**NEUROLOGICAL**	**MUSCULOSKELETAL**
☁ CHRONIC FATIGUE	☁ RINGING OF THE EARS	☁ MUSCLE ACHES
☁ TOBACCO USE	☁ HEADACHES	☁ TROUBLE WALKING
☁ ALCOHOL ABUSE	☁ MIGRAINES	☁ JOINT STIFFNESS
☁ CANCER	☁ ARTHRITIS	☁ MUSCLE WEAKNESS
☁ DIZZINESS	☁ LEG/FOOT NUMBNESS	☁ OSTEOPOROSIS
	☁ SEIZURES	☁ JOINT REPLACEMENT
RESPIRATORY	**GASTRO-INTESTINAL**	**ENDOCRINE**
☁ SHORTNESS OF BREATH	☁ DIARRHEA	☁ HOT FLASHES
☁ ASTHMA	☁ CHRON'S DISEASE	☁ HAIR LOSS
☁ PNEUMONIA	☁ DIGESTIVE ISSUES	☁ TYPE 1 DIABETES
☁ Long COVID	☁ CONSTIPATION	☁ TYPE 2 DIABETES
	☁ GALLBLADDER ISSUES	☁ MENSTRUAL ISSUES
	☁ LIVER PROBLEMS	☁ HYPOTHYROIDISM
		☁ HYPERTHYROIDISM
EARS, EYES, NOSE, THROAT	**GENITO-URINARY**	**CARDIOVASCULAR**
☁ ALLERGIES	☁ URINARY ISSUES	☁ EASILY BRUISED
☁ THROAT ISSUE	☁ KIDNEY ISSUES	☁ POOR CIRCULATION
☁ EAR PROBLEM	☁ KIDNEY STONES	☁ HIGH BLOOD PRESSURE
☁ NOSE PROBLEM	☁ BED WETTING	☁ LOW BLOOD PRESSURE
☁ EYE PROBLEM	☁ PROSTATE PROBLEM	☁ HEART DISEASE
		☁ HEART ATTACK
		☁ HIGH CHOLESTEROL
		☁ STROKE
		☁ PACEMAKER

How would your life change if you didn't have the health conditions you indicated on this form?

_____

Brookside Chiropractic Fee Schedule

New Patient Consultation Fee $150

* This is a *one-time, non-negotiable fee*, which is NOT subject to MOST insurance coverage. Only some Plans will reimburse for the exam portion. The first adjustment is usually included in this cost.

Chiropractic Adjustment: 1-2 regions: $45 / 3-4 regions: $50 / 5 regions: $55

Massage Therapy 1 hour = $63

Laser Therapy: 1 region: $30 2 or more regions: $50

*** Class IV Laser Therapy is NOT covered by insurance.**

Electrical Muscle Stimulation: $15

Traction/Decompression: $15

Infrared Heating Pad: $10

* If your insurance company does not reimburse for certain treatments, you are responsible for the fee.

By signing I agree to abide by Brookside Chiropractic Fee Schedule and understand that payment is due at the time of service.

Sign _____ **Date** _____

Consent to Chiropractic Services

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, diagnostic x-ray, or tests Dr. Rachel or Dr. Travis Tourjee and their staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the doctor and/or with office personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

Signed _____ **Date**_____