NEW PRACTICE MEMBER PAPERWORK

13 YEARS – 17 YEARS OLD

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Dr. Shauna B. Murphy, D.C.

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CALHOUN CHIROPRACTIC
Wellness Center

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CONFIDENTIAL HEALTH INFORMATION

Please thoroughly and neatly complete this application. Thank You.

_____ Today's Date

_____ Preferred Name (Nickname)

Gender
◯Male ◯Female

_____ Last Name

_____ First Name _____ Middle Name

_____ **Birth Date** (MM/DD/YYYY) _____ Age

_____ Address

_____/_____/_____ Father's Name Father's Date of Birth

_____ City _____ State _____ ZIP

_____/_____/_____ Mother's Name Mother's Date of Birth

_____ Home Phone _____ Cell Phone

_____/_____/_____ Legal Guardian Date of Birth

_____ Email Address

_____/_____/_____ Other Legal Guardian Date of Birth

_____ Emergency Contact Emergency Contact Phone

_____ Job (if applicable)

_____ For how long?

_____ Employer

_____ Work Phone

_____ Primary Care Provider's Name

_____ Provider's Office Phone

Have you consulted a Doctor of Chiropractic before?
◯No ◯Yes

Whom can we thank for referring you to our office? _____

_____ If so, whom? _____ When?

_____ Weight (approx.) _____ Height _____ Shoe size

Are you allergic to anything? ◯Yes ◯No

If yes, what? _____

Are you Right or Left handed? _____

INITIALS _____

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. Are the symptoms a result of (darken circle): ◯ A new problem
◯ A long-term problem; Is it worsening? ◯ Yes ◯ No
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)
_____
_____

4. Intensity (How extreme are your current symptoms?)
0 1 2 3 4 5 6 7 8 9 10
Absent Uncomfortable Agonizing

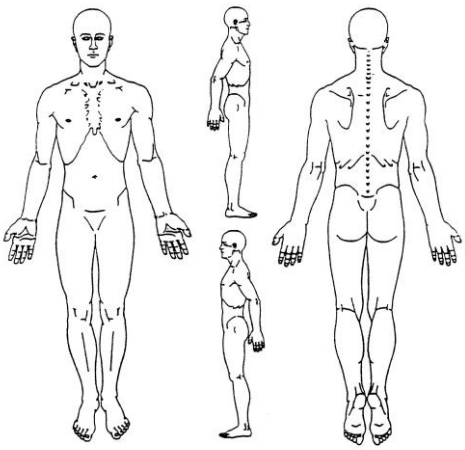
5. Duration (How often do you feel it?)
◯ Constant (75-100% of Time)
◯ Frequent (50-74% of Time)
◯ Intermittent (25-49% of Time)
◯ Occasional (0-24% of Time)

6. Quality of symptoms
What does it feel like?)

◯Aching ◯ Sharp
◯Burning ◯ Shooting
◯Cramping ◯ Spasms
◯Dull ◯ Stabbing
◯Itching ◯ Stiffness
◯Nagging ◯ Throbbing
◯Numbness ◯ Tingling
◯Pulling ◯ Other:

_____
_____

7. Location (Where does it hurt?)
Mark the area(s) on the illustration.
"O" for current condition
"X" for past condition



8. Radiation (Does it affect other areas of your body? To what areas do the symptoms radiate, shoot or travel?)
_____
_____

9. Aggravation or relieving factors (What makes it better or worse, such as time of day, movement, certain activities, etc.)
What tends to worsen the problem? _____
_____
What tends to lessen the problem? _____
_____

10. How often does it bother you?
Days per week? _____
Days per month? _____
Other? _____

11. Prior interventions (What have you done to relieve symptoms?)
◯Prescription medication ◯Surgery
◯Over-the-counter drugs ◯Acupuncture
◯Homeopathic remedies ◯Chiropractic
◯Physical therapy ◯Ice
◯Massage ◯Heat
◯Other_____

12. When does it bother you the most? ◯ Morning ◯ Afternoon ◯ Evening ◯ Night time when sleeping

13. Does it wake you up at night? ◯ Yes ◯ No **About what time and why/how?** _____

14. How does your current condition interfere with your quality of life in the following areas?

Job/Chores
0 1 2 3 4 5 6 7 8 9 10
no affect completely

Recreational Activities
0 1 2 3 4 5 6 7 8 9 10
no affect completely

Household Responsibilities
0 1 2 3 4 5 6 7 8 9 10
no affect completely

Personal Relationships
0 1 2 3 4 5 6 7 8 9 10
no affect completely

15. What else should we know about your current condition? _____

16. Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle next to any condition or body part that you've **HAD** or currently **HAVE** pain.

(a) *Musculoskeletal:* **None** ◯

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck	◯	◯	Back	◯	◯	Hip disorder
◯	◯	Knee	◯	◯	Foot/Ankle	◯	◯	Shoulder	◯	◯	Elbow/Wrist	◯	◯	TMJ	◯	◯	Poor posture

(b) *Neurological:* **None** ◯

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Numbness	◯	◯	Pins and needles

(c) *Cardiovascular:* **None** ◯

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

(continued from previous page)

INITIALS _____

(d) Respiratory: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

(e) Digestive: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/ Bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

(f) Sensory: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing ears	○	○	Hearing loss	○	○	Chronic ear infections	○	○	Loss of smell	○	○	Loss of taste

(g) Skin: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

(h) Endocrine: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy

(i) Genitourinary None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms

(j) Constitutional: None ○

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○	○	Weakness

(k) Other: _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

17. Illnesses

Check the illnesses you have **HAD** or **HAVE**.

Had	Have		Had	Have	
○	○	Alcoholism	○	○	Rheumatic fever
○	○	Allergies	○	○	Typhoid fever
○	○	Arteriosclerosis	○	○	Scarlet fever
○	○	Cancer	○	○	Stroke
○	○	Chicken pox	○	○	Tuberculosis
○	○	Diabetes	○	○	Typhoid fever
○	○	Epilepsy	○	○	Ulcer
○	○	Glaucoma	○	○	Other: _____
○	○	Goiter			_____
○	○	Gout			_____
○	○	Heart disease			_____
○	○	Malaria			
○	○	Measles			
○	○	Multiple sclerosis			
○	○	Mumps			
○	○	Polio			

18. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____
- _____
- _____

19. Treatments

Check the ones you've received in the **PAST** or are receiving **CURRENTLY.**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

LIST OF SUPPLEMENTS: _____

_____

○ ○ Medications

LIST OF MEDICATIONS: _____

_____

20. Injuries:

Injured in an accident

- ○ Spine or nerve disorder
- ○ Knocked unconscious
- ○ Broken bone(s): _____
- ○ Used a crutch or other support
- ○ Used a neck or back brace
- ○ Received a tattoo or piercing

21. Family History *Some health issues are hereditary. Please tell us about the health of your immediate family members.*

FAMILY

Please check if any of your blood relatives have/had any of the following illnesses and mark accordingly by noting, M (mother), F (father), S (sibling), PGM (paternal grandma), MGM (maternal grandma), PGF (paternal grandfather), MGF (maternal grandfather):

_____Allergy ○Have ○Had	_____Asthma ○Have ○Had	_____ Eczema ○Have ○Had	_____ Cancer○ Have ○Had
_____Low blood sugar ○Have ○Had	_____Heart trouble ○Have ○Had	_____ High blood pressure○ Have ○Had	_____ Stroke○ Have ○Had
_____Kidney disease ○Have ○Had	_____Liver disease ○Have ○Had	_____ Mental retardation ○Have ○Had	_____ Autism ○Have ○Had
_____Mental illness ○Have ○Had	_____Scoliosis ○Have ○Had	_____ Ulcer ○Have ○Had	_____ Diabetes ○Have ○Had

Please list all blood relatives who have passed away, the cause of death, and their age of death: _____

_____

_____

22. List any other illnesses or conditions that are hereditary: _____

INITIALS _____

23. Social History

Please tell us about your health habits and stress levels.

SOCIAL

Alcohol use	○Daily	○Weekly	How much? _____	Prayer?	○Yes	○No
Coffee use	○Daily	○Weekly	How much? _____	Meditation?	○Yes	○No
Tobacco use	○Smoke	○Chew		Job pressure/stress?	○Yes	○No
	○Daily	○Weekly	How much? _____	Financial Peace?	○Yes	○No
Vaping	○Daily	○Weekly	How much? _____	Vaccinated?	○Yes	○No
Exercising	○Daily	○Weekly	How much? _____	Mercury fillings?	○Yes	○No
Pain relievers	○Daily	○Weekly	How much? _____	Recreational drugs?	○Yes	○No
Soft drinks	○Daily	○Weekly	How much? _____			
Water intake	○Daily	○Weekly	How much? _____			

Hobbies: _____

Exercise regimen: _____

24. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Being Bullied	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life/dating	○	○	○	○
Getting sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

25. Do you wear custom orthotics/shoe inserts? ○Yes ○ No **26. If so, how old are they?** _____

27. What is the major stressor in your life? _____ **28. How much sleep do you average per night?** _____ **Hours**

29. How old is your mattress (approx.)? _____ **pillow?** _____ **30. What is your preferred sleeping position?** _____

31. Describe your typical eating habits: ○Skip breakfast ○Two meals a day ○Three meals a day ○ Snacking between meals ○Eat after dinner

32. What would be the most significant thing that you could do to improve your health? _____

_____

33. In addition to the main reason for your appointment today, what additional health goals do you have? _____

_____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement:

Parent Initials _____ **It is my desire that the chiropractor deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I understand that the chiropractic care offered in this practice is based on the best available evidence and is designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct from allopathic medicine and does not proclaim to cure any named disease or entity.**

Parent Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Parent Initials _____ **FOR WOMEN: I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Parent Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Parent Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Parent Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ _____ _____

Print Name **Signature** **Date**

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DISCLAIMER NOTICE

I understand that the doctors at Calhoun Chiropractic Wellness Center will be providing me with chiropractic treatment.

I fully understand that there is no guarantee that such treatment/care will improve my condition. Many practice members have been treated by chiropractors for various conditions, some of which respond to treatment, and others which may not, despite the best of care.

I understand that it is my responsibility to keep an open line of communication with my doctor of my progress. Chiropractic treatment by nature often involves frequent office appointments to maximize the benefits of the care.

Consent for Radiology

I give the doctors at Calhoun Chiropractic Wellness Center my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office.

If I am pregnant or know of any contraindications for x-rays at this time I will inform the doctor(s) before any x-rays are taken and will provide them here.

Contraindications for x-rays: _____

_____

Print Name: _____ Date: _____

Your Signature: _____

Witness: _____