Office Use: SU☐ FE☐ FP☐ SN☐

Patient Information Form.

Please fill information out in detail, as this is important to your case.

Today's Date _____/_____/_____

First Name_____ M.I.____ Last Name _____ Nickname _____

Address_____

City_____ State_____ Zip_____

E Mail_____

CELL ( )_____ Home ( )_____

Sex: ☐M ☐F Marital Status ☐S ☐M ☐W ☐D

Your Age Today _____ & Date Of Birth _____/_____/_____

Spouse's Name _____ # Children____

Patient's Occupation_____ Work Phone( )_____

Patient's Employer_____

Work Address_____

Emergency Contact_____Phone#_____

Person Responsible for this Account _____

How did you hear about us? ☐Google ☐Facebook ☐other _____

Patient's/Guardian's Signature_____ Date _____/_____/_____

BRENNAN
FAMILY
CHIROPRACTIC

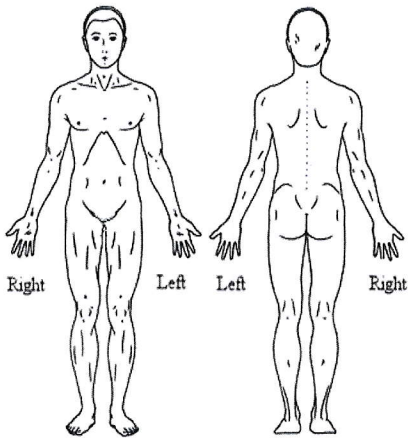
Brennan Family Chiropractic, 221 N Elm St., Cresco, IA. 52136 – (563)203-3900

Brennan Family Chiropractic Patient Intake Questionnaire

Name: _____ **Today's Date:** _____ / _____ / 20_____

Reason For Visit: ❑Pain Symptoms ❑Wellness Visit ❑Auto Accident ❑Work Related Injury ❑Sports Injury

Please Describe the Pain and Place an "X" on the Picture for Location(s) of Your Pain: Draw arrow to illustrated radiating pain →



Can be described as: ❑**Sharp** ❑**Dull** ❑**Stiffness** ❑**Soreness**

Severity: ❑ Severe ❑ Moderate ❑ Mild ❑Slight

Frequency: ❑ Constant ❑ Frequent ❑Occasional ❑Intermittent

Quality: ❑**Weakness** ❑**Discomfort** ❑**Burning** ❑**Tingling** ❑**Swelling** ❑**Spasm**

Other Conditions: ❑Headache ❑Migraine ❑Earache ❑Sciatica on Left ❑Sciatica on Right ❑TMJ pain ❑Fatigue ❑Decreased bending ❑Pain on Movement

Onset of Pain: ❑Gradual ❑Sudden ❑Sleeping ❑Auto Injury ❑Sports injury ❑Work Injury

Onset Time of pain: ❑Today ❑Yesterday ❑Past Week ❑Past Month ❑Past Year (approx date)_____ Long Time Ago (Approx Date) _____

Explain what you believe caused the pain: _____

Describe How You Feel: on a Scale of 1 (mild) to 10 (severe)

Circle JUST One: 1 2 3 4 5 6 7 8 9 10

Additional Complaints: _____

What Activities of Daily Living are you unable to perform due to your pain?

❑Working ❑Standing ❑Driving ❑Family Care ❑Sleeping ❑Stairs ❑Lifting ❑Walking ❑Sitting ❑Self Care ❑Dressing ❑Bending ❑Exercise ❑Family Care

What Activities Exacerbate (Flare-up) your condition?

❑Treatments ❑Standing ❑Working ❑Hip Twisting ❑Exercise ❑Lifting ❑Sleeping ❑Sitting ❑Neck Twisting ❑Bending ❑Driving ❑Computer Work

What Activities Give Relief?

❑**Treatment** ❑**Resting** ❑**Lying** ❑**Orthotic Support** ❑**Ice** ❑**Therapy** ❑**Sitting** ❑**Exercise** ❑**Heat** ❑**Stretching** **Other**_____

PAST HISTORY continued: Name: _____

Have you Been Treated for this Current Condition in the Past?

❑ Yes ❑ No When? _____ By Whom? _____

What other conditions have you been treated for? (Explain in detail)

_____

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

Medical History – (Check all that apply)

☐ Diabetes	☐ Arthritis	☐ AIDS	☐ Sciatica	☐ Bursitis	☐ Osteoporosis
☐ Alzheimer	☐ Kidney Dis.	☐ Gout	☐ Amputation	☐ Ulcers	☐ High Blood Pressure
☐ Cancer	☐ Heart Attack	☐ Stroke	☐ COPD	☐ Scoliosis	☐ Low Blood Pressure
☐ Ulcers	☐ Deafness	☐ Blindness	☐ Migraines	☐ Disc Disorder	☐ Neuralgia
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	☐ Varicose Vein	☐ Convulsions
☐ Fainting	☐ Sweats	☐ Chills	☐ Nervousness	☐ Eczema	☐ Prostrate Trouble
☐ Bleeding	☐ Tonsillitis	☐ Earache	☐ Hemorrhoids	☐ Pregnancy	☐ Neuro-Muscular Disease

☐ Other: (Be specific) _____

Brief Family History of Illness/Disease:

_____

List any Current Allergies: (Be specific)

_____

Current Medications You are Taking: (Be specific)

_____

_____

Social Activities:

❑ Smoke Cigarettes ____ # packs per day ❑Smoke Cigars ❑ I don't smoke

❑ Drink Alcohol Beverages ___ # per day, or ___ # per week ❑ I don't drink alcohol.

❑Beer ❑Wine ❑ Mixed Drinks

❑ I admit to history of Recreational Drug Use. ❑ I deny history of Recreational Drug Use.

❑ I am currently pregnant. Due Date: _____

I desire:

❑Just pain relief ❑Pain relief & correction of problem ❑Relief/Correction/Wellness care

Comments: _____

_____

Healthcare is Always Changing

Several items are needed and recognition of items.

Informed Consent Form – Dr. Arthur Brennan, D.C.

Patient Name _____ **Date** _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination, tests, various modes of physical therapy and/or diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me, while employed by, work for, or at, the office, or at any other related office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature, purpose and any risks of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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, strokes, dislocations, paralysis and strains/sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature: _____ **Date:** _____

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