Please Complete All Pages

Today's Date: _______ / _______ / _______

Patient Information

Patient Name: ____

Gender: M / F SSN: _______- _____ - _________ DOB: ______________ Age: ___________

Height: __________ FT ___________Inches Weight: _______________________ lbs.

Address: ________________________________ City: ____________________________Zip __________

Best Phone Number to Contact You: ____

Email: ____

In Case of Emergency Contact: Name: _____________________ Phone: __________________________

Relationship to Patient: ____

Primary Care Physician: ____

Office Address: __________________________________ Office Phone: __________________________

Date of Last Visit to Primary Care Physician: ____

Are you currently being treated for any condition (s)? ____

____

Are you taking any medications or supplements? If yes, please list them:
____

Are you interested in supplements / natural alternatives to manage your condition? ○ Yes / ○ No

Have you ever been treated by a Chiropractor? ○ Yes / ○ No

Doctor's name:______________________ Office Location: ____________________________________

Have you ever heard a "Pop" / "Crack" / "Snapping" sound while you were adjusted? ○ Yes / ○ No

What chiropractic treatments have you had in the past? ______________________________________

How did you hear about the Fuhrmann Health Center: _______________________________________

Current Problem

Purpose of this appointment: ____

Goal for this appointment: ____

When did this start?____

Have you had this in the past? __________ Have you seen any other medical professionals? _________

What decreases the pain / makes you feel better? ____

What makes the pain worse? ____

Describe your condition: ____

____

____

____

Does the pain travel into your arms / legs, hands / feet? _______________________________________

When does it hurt the worst? ____

Is your current condition accident related? Vehicular Work related Slip / Fall Sports

Date of Accident: _____________________

Did you receive diagnostic imaging? (X-ray, CT scan, MRI, bone scan, other):_______________________

Body area imaged: ______________________________ Facility: ___________________ Date:________

Insurance Carrier: (comp / no fault) _________________ Claim# _______________________________

Rate your pain: Please circle one.

0
No Pain

1 - 2
Mild Pain

3 - 4
Moderate Pain

5 - 6
Severe Pain

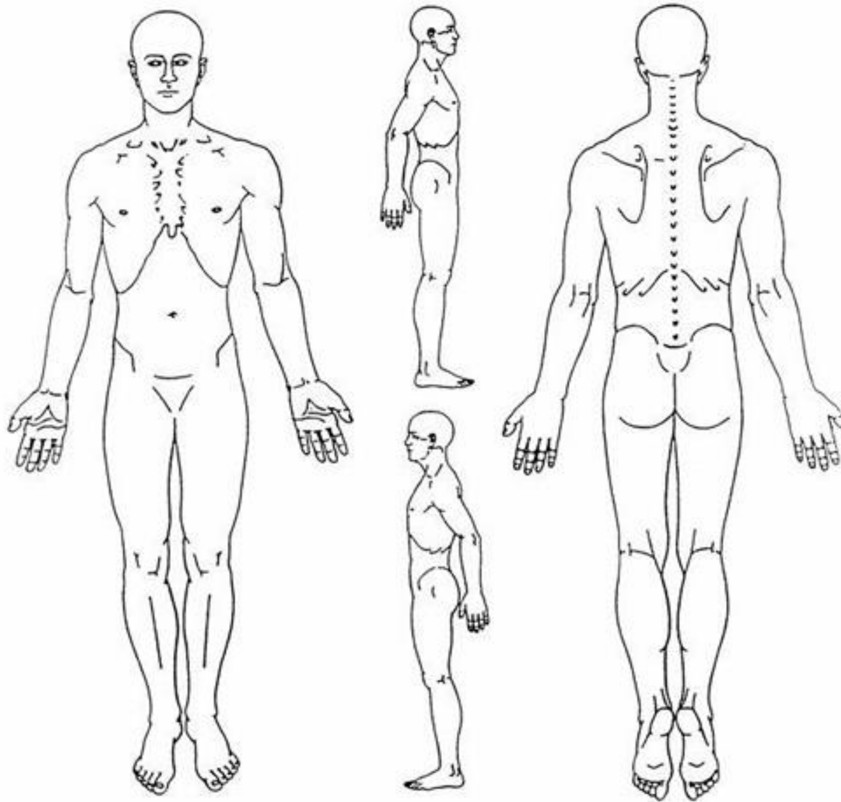
7 - 8
Very Severe Pain

9 - 10
Worst Possible Pain

Please draw the location of your pain:

Use these letters to represent the type (s) of pain you are experiencing:

D = Dull	S = Stabbing / Cutting	N = Numbness
B = Burning	T = Tingling (pins & needles)	C = Cramping



Please indicate if the following **increases**, **decreases** or has **no effect** on your symptoms:

Coughing, sneezing or bearing down:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Sitting:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Standing:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Walking:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Bending forward:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Lifting / carrying:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**
Arising from a sitting position:	○ **INCREASES** ○ **DECREASES** ○ **NO EFFECT**

What do your symptoms prevent you from doing? ____

____

____

Health History: Please indicate if you have / had the following conditions.

High / Low blood pressure	Stroke / Heart attack	HIV / AIDS
Alcoholism / Drug addiction	Frequent neck pain	Frequent headaches
Diabetes	Tuberculosis	Fainting / Seizures
Pacemaker	Spinal Surgery	Shingles
Difficulty breathing	Psychiatric condition	Kidney problems
Sinus Problems	Heart condition	Lung condition
Artificial bone / joints	Anemia	Cancer
Tumor	Chemotherapy	Arthritis
Unexplained weight loss	Night pains	Fatigue

Does anybody in you immediate family have any of the above conditions? Please explain:

____

____

____

Have you had any major accidents or surgeries? Please explain:

____

____

Do you smoke cigarettes? ○ Yes / ○ No Packs per day? __________ Number of years: _________

Do you drink alcohol? Drinks per week ____________ Do you use Cannabis? ○ Yes / ○ No

Do you use recreational drugs? ○ Yes / ○ No **_* This information is kept confidential_**

How many hours of sleep (on average) you do get? _______ How old is your mattress?_____________

Have there been any changes in bowel or bladder function? ○ Yes / ○ No

Has there been any recent unexplained weight loss? ○ Yes / ○ No

PLEASE READ THIS and ASK ANY QUESTIONS BEFORE SIGNING:

Consent for Treatment:

The purpose of spinal manipulation is to relieve pain & restore joint mobility. This is accomplished by manually applying a controlled force into joints of the spine that have become restricted in normal movement. Muscle strains, ligament sprains, tissue damage, disc herniation, and spinal misalignment can be caused by a single traumatic event (improper lifting, slip / fall, accident) or through repetitive stress (prolonged sitting / standing, poor posture, repetitive motion) The injured tissues undergo physical and chemical changes that can cause inflammation, pain, and decreased function. Adjusting restricted joints restores mobility, alleviates pain, decreases muscle tightness, and allows for tissues to heal properly.

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications are very rare, but may include fracture, muscular strain, ligamentous sprain, dislocation, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. The most common side effect of chiropractic care is stiffness or soreness after the first few treatments. Redness, skin irritation, bruising are possible with some therapies. This is considered normal and is easily alleviated by ice as recommended by Dr. Fuhrmann.
The risk of cerebrovascular injury or stroke is 1: 20 million. Evidence that chiropractic treatment causes strokes is lacking. Dr. Fuhrmann is well trained to screen for this possibility.

Other treatment options to consider may include:

- Over-the-counter analgesics: The risk of these medications includes irritation to the GI, Liver and kidneys. These do not need a prescription from a medical doctor.
- Medical care: typically anti-inflammatory drugs, tranquilizers and analgesics. There are a multitude of undesirable side effects and a risk of drug dependence.
- Other conservative care providers: Massage therapy, physical therapy and acupuncture may also help with your condition.

Risks of remaining untreated: Delay of treatment allows the formation of adhesions, scar tissue and degenerative changes that further reduce motion and induce chronic pain cycles. Complications of delaying treatment can worsen your condition and make future rehabilitation more difficult.

The above information is true to the best of my knowledge. I understand and agree that I am personally responsible for payments of fees incurred at this office. I authorize Dr. Nicholas A. Fuhrmann to gather / release all medical records to appropriate sources on my behalf. I hereby authorize the doctor to administer a physical examination, laboratory procedures or any other clinical service deemed necessary to reach a clinical diagnosis/ decision needed to develop an appropriate treatment plan. I also understand some of the procedures or maneuvers performed by the doctor may be intended to reproduce my symptoms and could cause temporary aggravation of my symptoms.

Patient's Signature____ Date: ___________

Parent / Guardian's Signature, if minor: _________________________ Relationship: _____________