*Bird Concierge Chiropractic*

*birdcc19@gmail.com*

Love, love that you have come to take charge of your health!!

We at Bird Concierge Chiropractic would like to welcome you to the family!! We know that you have many options when choosing someone to partner with in your healthcare and we thank you for entrusting your chiropractic care to us!

At Bird Concierge Chiropractic, our mission is to help families, via education, treatment, encouragement and celebration to live healthier and more productive lives; thereby strengthening families and community.

We encourage our patients to learn more about healthy living, to empower them in their own search for Health - we will meet you where you are and help you achieve your health goals. We promise to always treat our patients with dignity and act with integrity in all our interactions. We know that sometimes pain or other health issues can keep us from enjoying our families as much as we'd like, our hope is that by helping you to reach your personal health goals, you can once again enjoy your family as fully as you'd like to.

In an effort to assist you in your health journey, we offer services that include: a gentle adjusting technique using an activator to align your spine, Webster technique for pregnant mothers and anyone with resolving low back or hip problems, corrective ergonomic muscular retraining, nutritional counseling, prepared childbirth classes for those needing that and other services as needed.

While every patient's experience with chiropractic care is unique and we can't guarantee your personal outcomes, some of the benefits that have been experienced by others are: a decrease in missed work/school, strengthened immune systems, better sleep, better coordination/balance, better mental focus, decreased headaches, increased ranges of motion, better stability, lower blood pressure, and just simply a better overall quality of life.

We are looking forward to serving you and your family for many years to come. If however, you ever find that your needs are not being met here at Bird Concierge Chiropractic, please notify us promptly and we will either make the necessary changes or refer you to another chiropractic service that may be a better fit - after all, we are all unique!!

Your partner in Health,

Dr. Joy, DC

*Bird Concierge Chiropractic*
*214-886-5816*
*birdcc19@gmail.com*

## General Information:

First Name _____Last Name_____M/F _____ DOB_____Date_____

Home Address_____City_____State_____Zip_____

Phone _____ cell/home? _____cell/home? email _____

main alternate

Emergency Contact Name / relationship _____Phone_____

Occupation_____ Main Job Duties_____

Percent of time spent ...Sitting _____% ...Standing _____% ....Manual Labour _____%

How did you hear about our clinic? ❒ Referral ❒ Website ❒ Facebook ❒ Yelp ❒ Radio ❒ Other_____

## Purpose of today's visit

What is the reason for today's visit?

❒ Wellness ❒ New injury ❒ Old Injury ❒ Chronic Pain

Are you here because you were injured at work, in a motor vehicle collision, or in another accident?

❒ yes ❒ no

## Description of Symptoms

How often do you experience these symptoms?

❒ Constantly ❒ Frequently ❒ Occasionally ❒ Sometimes

If present, how could you describe the discomfort?

❒ Sharp ❒ Numb ❒ Dull ❒ Tingly ❒ Diffuse ❒ Achy ❒ Sharp w/movement

❒ Burning ❒ Electric-like ❒ Other _____

How long have you had this problem?

_____

How do you think your problem began?

_____

_____

Did it come on gradually or suddenly?

❒ gradually ❒ suddenly

Have you had this problem before?

❒ yes ❒ no if yes, when? _____

What makes your condition better?_____

What makes it worse? _____

Have you consulted someone else about this issue? What was done? Did it help? _____

_____

Are there any other complaints or issues? _____

_____

**Patient Initials** _____

_____ _____

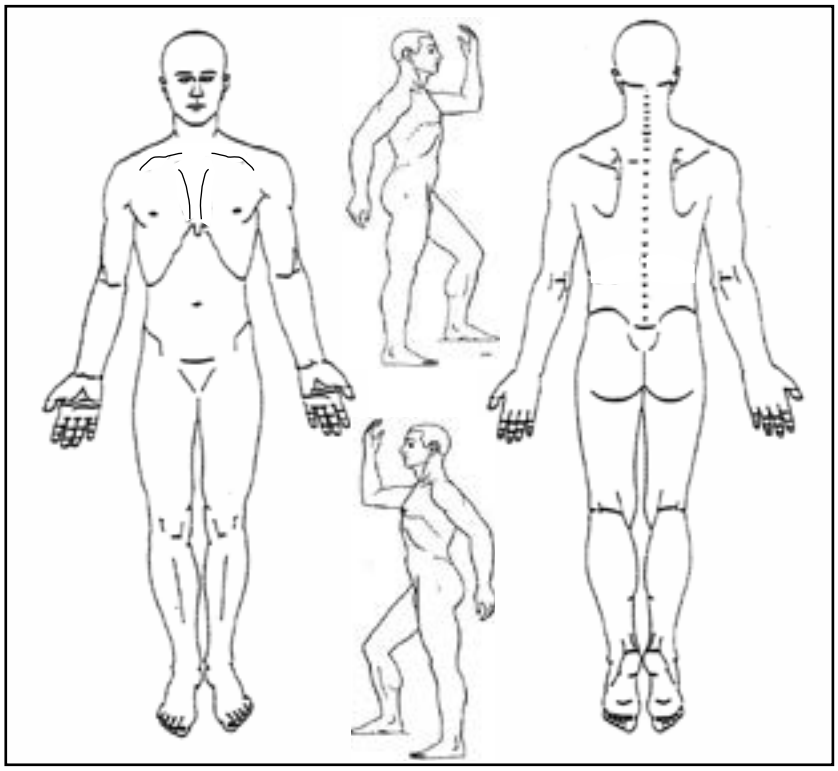
Doctor's Signature Date

Patient Name:_____ DOB:_____ Date: _____

## Location of Pain:

Please place the corresponding symbols on the diagram below as they relate to your pain/symptoms.

| | | |
|---|---|---|
| Shap Pain | Achiness | Burning |
| ////////// | xxxxxx | ^^^^^^ |
| Pins and Needles | Numbness | Other |
| !!!!!!!!!! | 000000 | ##### |



## Level of Pain:

Mark the severity of your chief complaint as it is right now.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ❍ 1. no symptoms | ❍ 2. Slight Discomfort | ❍ 3. Does Not Affect Activity | ❍ 4. Prevents Personl Activities | ❍ 5. Limits My Work Schedule | ❍ 6. Prevents All Working Activity | ❍ 7. Prevents All Working Activity | ❍ 8. Keeps Me Bedridden | ❍ 9. Keeps Me Bedridden | ❍ 10. Causes Thoughts of Suicide |

Mark the severity of your chief complaint as it is on average.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ❍ 1. no symptoms | ❍ 2. Slight Discomfort | ❍ 3. Does Not Affect Activity | ❍ 4. Prevents Personl Activities | ❍ 5. Limits My Work Schedule | ❍ 6. Prevents All Working Activity | ❍ 7. Prevents All Working Activity | ❍ 8. Keeps Me Bedridden | ❍ 9. Keeps Me Bedridden | ❍ 10. Causes Thoughts of Suicide |

Mark the severity of your chief complaint as it is at its best.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ❍ 1. no symptoms | ❍ 2. Slight Discomfort | ❍ 3. Does Not Affect Activity | ❍ 4. Prevents Personl Activities | ❍ 5. Limits My Work Schedule | ❍ 6. Prevents All Working Activity | ❍ 7. Prevents All Working Activity | ❍ 8. Keeps Me Bedridden | ❍ 9. Keeps Me Bedridden | ❍ 10. Causes Thoughts of Suicide |

Mark the severity of your chief complaint as it is at its worst.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ❍ 1. no symptoms | ❍ 2. Slight Discomfort | ❍ 3. Does Not Affect Activity | ❍ 4. Prevents Personl Activities | ❍ 5. Limits My Work Schedule | ❍ 6. Prevents All Working Activity | ❍ 7. Prevents All Working Activity | ❍ 8. Keeps Me Bedridden | ❍ 9. Keeps Me Bedridden | ❍ 10. Causes Thoughts of Suicide |

Patient Initials _____

_____ _____

Doctor's Signature Date

Patient Name:_____ DOB:_____ Date: _____

**REVIEW OF SYSTEMS:** Check any that apply

General
[ ] Weight gain/loss (circle)
[ ] Loss of Appetite
[ ] Fevers
[ ] Weakness
[ ] Fatigue
[ ] Allergies

Musculoskeletal
[ ] Joint Pain
[ ] Leg Cramps
[ ] Back Pain
[ ] Neck Pain
[ ] Arm Pain
[ ] Leg Pain
[ ] Muscle Pain
[ ] Any kind of Bone Disease

Neurological
[ ] Sudden Numbness
[ ] Sudden Headache
[ ] Tingling
[ ] Fainting
[ ] Confusion
[ ] Slurred Speech
[ ] Loss of Balance
[ ] Dizziness
[ ] Difficulty Walking
[ ] Memory Loss

Hematology
[ ] Easy Bruising
[ ] Bleeding slow to Clot

Dermatology
[ ] Rash
[ ] Flushing
[ ] Slow Healing Wounds
[ ] Dry/Flaky Skin

Cardiovascular
[ ] High Blood Pressure
[ ] Heart Disease
[ ] Irregular Heartbeat
[ ] Bleeding Disorder
[ ] Chest Pain
[ ] Varicose Veins
[ ] Sweating
[ ] Swelling of ankles/wrists

Respiratory
[ ] Shortness of Breath
[ ] Congestion
[ ] Cough
[ ] Short on Breath w/Exertion
[ ] Asthma
[ ] COPD
[ ] Pneumonia
[ ] Emphysema

Ophthamology
[ ] Blurred Vision
[ ] Double Vision
[ ] Diminished Vision
[ ] Vision Floaters
[ ] Glaucoma
[ ] Cataracts
[ ] Night Blindness
[ ] Discharge

Male Reproductive
[ ] Difficulty with Erections
[ ] Frequent need to Urinate

Female Reproductive
[ ] Pregnant
[ ] Menopause
[ ] PMS Issues

Gastrointestinal
[ ] Nausea/Heartburn
[ ] Diarrhea
[ ] Constipation
[ ] Difficulty Swallowing
[ ] Abdominal Pain/Discomfort
[ ] Irregularity (Less than 1-2 bowel movements/day)

Genitourinary
[ ] Kidney/Bladder infection
[ ] Loss of Bladder Control
[ ] Urine Color Change
[ ] Painful/Burning Urination
[ ] Urine Leakage
[ ] Urgency
[ ] Blood in Urine

Mental/Emotional
[ ] Depression
[ ] Anxiety
[ ] High Stress

Disease History
[ ] Stroke
[ ] Heart Attack
[ ] Endocrine _____ (Ex: Diabetes, Thyroid, Adrenal, etc...)
[ ] Cancer
[ ] HIV/AIDS
[ ] Arthritis, type_____
[ ] Neurological Problems
[ ] Multiple Sclerosis

Family Disease History (who?)
[ ] Stroke
[ ] Heart Attack
[ ] Endocrine _____ (Ex: Diabetes, Thyroid, Adrenal, etc...)
[ ] Cancer
[ ] HIV/AIDS
[ ] Arthritis, type_____
[ ] Neurological Problems
[ ] Multiple Sclerosis

**Patient Initials** _____

_____ _____
Doctor's Signature Date

Patient Name:_____ DOB:_____ Date: _____

## Health Habits and History: (Please use other side if more space is needed.)

**List any past surgeries:** _____

**List any past hospitalizations:** _____

**List any past traumas not already mentioned:** _____

**List any medications you are taking:** _____

**List any over-the-counter medications you are taking:** _____

**List any supplements you are taking:** _____

**Do you smoke? Y/N Did you smoke and quit? Y/N How much?** _____

**Do you drink alcohol? Y/N If yes, how much/week?** _____

**Do you drink coffee? Y/N If yes, how many cups/day?** _____

**Do you drink sugary beverages? Y/N If yes, how many/week?**_____

**Sleep - do you have any issues with (circle if applies): Snoring? Daytime Drowsiness? Difficulty Falling Asleep? Early Morning Awakening? Interrupted Sleep? Other?** _____

**How committed are you to spending 10-15 minutes/day performing exercises that will enhance your results?**
[ ] Not Interested at All [ ] May Do if I can Find the Time [ ] I will Do it Most of the Time, but I Have Other Priorities
[ ] Fully Committed to Doing it, No Matter What

**What, if any, exercises/activities do you do on a weekly basis?**_____

**What healthy activities are you interested in starting?**_____

**How many servings of fruits and vegetables do you eat every day?** _____ **Water?** _____

## Financial policy:

**Payment is due at the time of service.** If you are not the person who is responsible for payment, please indicate who is below:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Name of responsible party | Address | Phone number | Relationship to patient |

**NO-SHOW POLICY:** If you do not cancel a scheduled appointment within 24 hours, and subsequently do not appear, a $20.00 charge will be added to your account, which will be due at your next visit.

## Privacy Issues:

I acknowledge that Bird Concierge Chiropractic has made available to me a copy of its Notice of Privacy. Initials_____

I have read the clinic's Financial Policy and any questions I may have had have been answered. Initials_____

I have read the clinic's No-Show policy, and I understand it. Initials_____

I acknowledge that these forms have been filled out to the best of my knowledge.

Printed Name _____ Signature _____ Date _____
*patient* *patient*

_____ _____
Doctor's Signature Date