Brian J. Chandler, D.C.
Chiropractic Physician

Main Office: 697 Hannah Ave., Ste. C
Traverse City, MI 49686
(231)922-9626

Drummond Island: 33896 S Townline Rd
Drummond Island, MI 49726
(906) 322-1815

Welcome to our office!

Today's Date ____/____/_____

Patient Title: Mr. Mrs. Ms. Miss Dr.
Name_____ Preferred Name _____
First Middle Last

Address _____
City _____State_____ Zip Code _____
Home Phone _____Cell Phone _____ Cell Carrier _____
Work Phone _____ Email Address _____
Preferred Contact Method: Home Phone Cell Phone Work Phone Email
Date of Birth ____/___/_____ Age _____ Gender: Male Female

Race: White/Caucasian Black/African American Hispanic Asian Other I choose not to specify

Marital Status: Single Married Widow/Widower Other

Spouse Name _____ Date of Birth _____ # of Children _____
Insurance purposes

Emergency Contact _____ Phone # _____Relationship _____
Referred by _____
Employment Status: Employed Retired Full-Time Student Part-Time Student Other
Occupation _____ Employer _____
Primary Physician _____

Health Information

Do you currently take any medications: Yes No

Medication Name	Frequency	Dosage	What Condition
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Are you allergic to any medications: Yes No
If yes, please list know allergies to medications: _____

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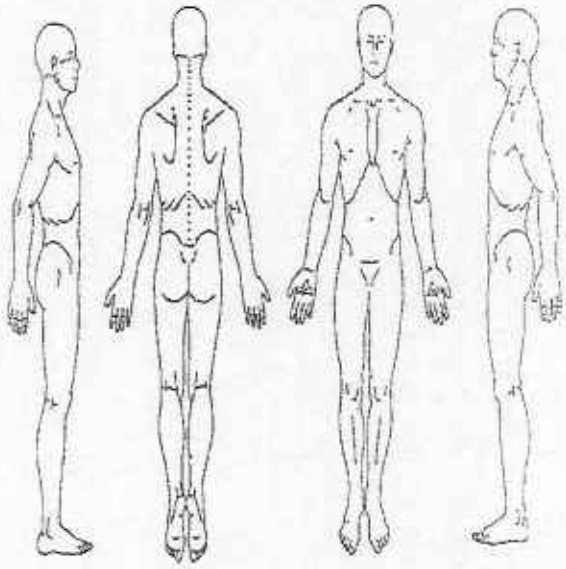
Current Problem

Reason for this visit? _____

What level of intensity would you rate your pain?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Mark location of pain of symptoms:



Please select all that applies:

Achy	Burning	Stiff	Deep	Dull
Numbness	Sharp	Shooting	Stabbing	Tingling Radiating
Cramping	Throbbing	Tightness	Stabbing	

What is the frequency of your symptoms?

Constant Frequent Intermittent Occasional

What makes your symptoms worse? _____

What makes your symptoms better? _____

When did your symptoms start? _____

How did you injure yourself? _____

Have you ever experienced this before? Yes No

How does this affect your personal life? (hobbies, sports, etc)

_____

How does this effect your job? (missed days, inability to lift, stand, sit, etc) _____

What home remedies have you tried? _____

Have you been to another doctor for this problem? Yes No

Have you ever been to a chiropractor before? Yes No _____

Does this affect any of the following tasks?

Bathing/Showing	Going to Bathroom	Bending forward	Lifting objects	Driving	Picking up kids
Brushing Teeth	Doing laundry	Bending left	Reaching	Golfing	Playing sports
Drying Hair	Preparing meals	Bending right	Standing	Exercise	Raking leaves
Cleaning	Putting on pants	Carrying objects	Stair Stepping	Hobbies	Shoveling snow
Combing hair	Putting on shirt	Getting up from a chair	Sitting	Home maintenance	Sleeping
Eating	Putting on shoes/socks	Kneeling	Twisting	Household chores	Swimming
Getting in/out of bed	Taking out trash	Leaning back	Walking	Mowing lawn	Yard work

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Have you ever.....

Yes No Been knocked unconscious? _____
Yes No Been in a car accident? _____
Yes No Been treated for a spine problem/nerve disorder? _____
Yes No Had any significant falls, slips, or injuries? _____
Yes No Fractured/Broken a bone? _____
Yes No Had surgery? _____
Yes No Been Hospitalized for other than surgery? _____
Last imaging taken (x-ray, MRI, CT) ? _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker
If yes, how often do you smoke? Every day smoker # Of packs per day _____ Sometimes smoker
If yes, what is your level of interest in quitting? 0 1 2 3 4 5 6 7 8 9 10
No Interest *Very Interested*

Do you consume alcohol? Yes No # of drinks per week? _____
Do you consume caffeine? Yes No Coffee Soda Tea Energy drinks # Of drinks per day _____
Do you exercise? No Infrequent Occasional Regular What type of exercise? _____

Please mark any you currently have or have had previously:

AIDS	Cramps	Kidney Infections	Sciatica
Alcoholism	Depression	Kidney Stones	Shortness of Breath
Allergies	Diabetes	Loss of Memory	Sinus Infection
Anemia	Digestions Problems	Loss of Balance	Sleep Problems/Insomnia
Arteriosclerosis	Dizziness	Loss of Smell	Spinal Curvatures
Arthritis	Excessive Menstruation	Loss of Taste	Stroke
Asthma	Eye Pain/Difficulties	Migraine Headache	Swelling of Ankles
Back Pain	Fatigue	Nervousness	Thyroid Condition
Bronchitis	Headache	Nosebleeds	Tuberculosis
Bruise Easily	Hemorrhoids	Pacemaker	Ulcers

Is there a family history of: (Include Relationship)

Heart Disease _____
Cancer _____
Stroke _____
Arthritis _____
Diabetes _____
High Blood Pressure _____
Other _____

Women Only

Are you pregnant? Yes No Maybe
Number of weeks _____
Estimated due date _____

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Habits and Lifestyle?

Do you sleep on your Side Stomach Back (circle all that applies)

How many hours on average do you sleep a night? _____

How old is your mattress? _____

How many ounces of water do you drink per day? _____

How may meals on average do you consume a day? _____

Are you on any special diets or dietary restrictions? _____

Current weight _____ (lbs) Height _____(ft) Last blood pressure reading _____

Are you concerned about your weight? _____ If so, what is your goal weight? _____(lbs)

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____

Patient Signature

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and inform you of your rights and our obligations concerning you health information.

The undersigned hereby acknowledges that you may receive/review, and understand and agree to the Notice of Privacy Practices, which describes the practice's and procedures regarding the use of disclosure of any of my Protected Heath Information created, received or maintained by Dr, Brian J Chandler, DC, Charles Strand, LMT, and Emily Hicks, LMT.

_____ _____

Patient/Guardian Signature Date

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Statement of Informed Consent

Before a treatment begins we will explain what areas need attention and what technique will be required. As the patient you will be asked of your comfort level and your open communication is imperative. You have the right to stop the treatment at any time if you feel uncomfortable.

Your comfort and modesty are very important to us. There are areas on the body (groin, chest, breast, gluteal, abdominal, and fascial areas) that are typically overlooked because of privacy or their personal nature. We feel that these areas may need to be addressed based on examination.

Myofascial release therapy, trigger point therapy and medical massage therapy are used to promote healing, reduce hypertonicity in muscle, break up adhesions between muscle fascias, promote tissue repair, and lymph drainage. These techniques are performed on areas deemed medically necessary after examination and evaluation by Dr. Brian Chandler DC, Charles Strand, LMT and Emily Hicks LMT based on your musculoskeletal dysfunction.

We use the technique that will give you the best a fastest outcome possible, however you as the patient are in control of the session.

Chiropractic adjustments are performed in our office by a skilled doctor of chiropractic who has successfully completed advance educational requirements, national board examinations, and state board examinations. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. Our doctor and staff make every effort possible to provide the most safe care available.

After these treatments some level of soreness can be expected and anticipated. By drinking plenty of fluids and not planning any strenuous activities that day can help mitigate some of the discomfort.

The undersigned hereby consent to evaluations and treatment rendered according to the applicable standards of care and I am aware of the treatments to be performed. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If proposed treatments are not clear to me, I understand that further information may be requested from the doctor or therapist. I give Dr. Brian Chandler DC, Charles Strand LMT, and Emily Hicks LMT permission to perform these treatments and agree to notify them of any discomfort or draping issues during the session.

_____ _____

Patient/Guardian Signature Date

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Assignment of Benefits

Assignment of Benefits is simply authorizing Dr. Brian J. Chandler, DC, Charles Strand, LMT and Emily Hicks, LMT, to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes Dr. Brian J. Chandler, DC, Charles Strand, LMT and Emily Hicks, LMT to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office.

I understand that I may withdraw my signature at any time. I also understand that I am ultimately responsible for all chares for which my insurance does not pay under the contractual agreement.

_____ _____

Patient/Guardian Signature Date