Marshalls Creek Chiropractic and Wellness Solutions
2490 Milford Road. East Stroudsburg, PA 18301.
(570) 223-7211 PH (570) 223-7545 FAX
Dr. Brett Coryell DC, DABCO
Dr. Anne Marie Coryell DC, DABCO, DICCP

Welcome to Marshalls Creek Chiropractic and Wellness Solutions. We are honored that you have chosen us as your health care provider. Our goal is to provide you with the highest quality care for all our patients in a timely and respectful manner.

We will do our best to provide you with same day office visits. You will need to bring your insurance card along with a photo ID on your first visit. Please let our staff know if you have had any information change since your last appointment.

All Co-pays and past due balances are expected at time of service, unless a prior agreement is set with our billing department.

We ask that you allow plenty of time to get to the office for your appointment.
We understand that appointments sometimes need to be changed, so we ask that you call 24 hours in advance if you cannot keep your scheduled appointment.

Our Office Hours Are as Follows:

Monday: 8am until 12pm and 2pm until 7pm
(On Staff Dr Brett Coryell)

Tuesday: 2pm until 7pm
(On Staff Dr. Anne Marie Coryell and Dr. Brett Coryell)

Wednesday: 8am until 12pm and 2pm until 7pm
(On Staff Dr Brett Coryell)

Thursday: 2pm until 7pm
(On Staff Dr. Anne Marie Coryell and Dr. Brett Coryell)

Friday: 8am until 12pm and 2pm until 7pm
(On Staff Dr Brett Coryell)

Welcome to our practice and thank you for choosing Marshalls Creek Chiropractic and Wellness Solutions for all your health care needs.

Sincerely,
Dr. Brett Coryell DC, DABCO
Dr. Anne Marie Coryell DC. DABCO, DICCP

Confidential Patient Health Record

Today's Date:___/____/_______

How did you hear about us? ☐ Family ______________ ☐ Friend _________________ ☐ Co-Worker _______________
☐ Close to home/work ☐ Dr. _____________ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan ☐ Internet

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Rev. ☐ Miss ☐ Prof. ☐ other: ______________________________

Last:_________________________ First:__________________________ Middle: ___________________________

Birth Date: ____ /____/_______ Age:______ Sex: Male / Female Social Security #: _______-_______-________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Height _______ Weight _______ __________

Address: ____Apt # ______

City: _________________ State: ______ Zip: _________ Country: _________________ County: _____________

Home Phone: (_______) _______-_________ ext ______ Work Phone: (_______) _______-_________ ext ______

Cell Phone: (_______) _______-_________ ext ______ Fax #: (_______) _______-_________ ext ______

Email Address: ____________________________ Spouses Name: _________________________________

Emergency Contact

Last:_________________________ First:__________________________ Middle: ___________________________

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other ________________

Home Phone: (_______) _______-_________ ext ______ Cell Phone: (_______) _______-_________

Employment Information

Business Name: ____

Address: ____Apt # ______

City: _________________ State: ______ Zip: _________ Country: _________________ County: _____________

Phone: (_______) _________-____________

Current Health Condition

Why you are here today?:____

When did this Condition BEGIN? _____/_______/_________ Has it ever occurred before? ☐ Yes ☐ No.

When? ____________________

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury ☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: ____

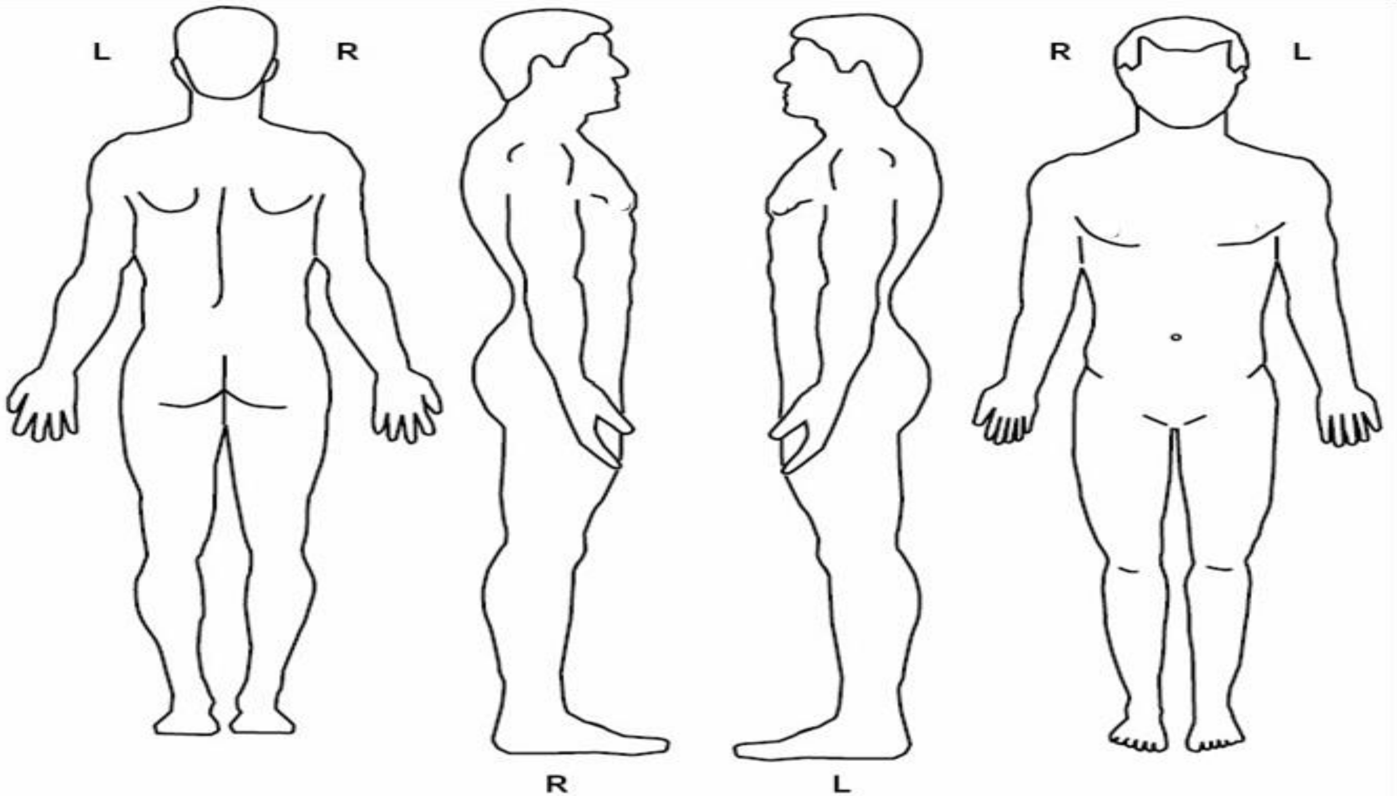
If Job related, Are you claiming Work Comp?________ Did you Report it?__________

Date of Accident: _________ Time of Accident: ________ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

Attempt to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ///////////////	**Pins & Needles** XXXXXXXX	**Burning Pain** BBBBBBB	**Stabbing Pain** SSSSSSS	**Aching Pain** AAAAAAA



Please complete each section that applies to your issues and skip the area's not applicable.

1: NECK

Condition: ☐ New → ☐ Acute or ☐ Chronic Started:________________Last Occurred:________________

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral ____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other ______________________________

Level of pain (At your best):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Level of Pain (At your worst):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Neck continued

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Context: *Better with:* ☐ Warm Temp ☐ Cold Temp ☐ Medication ☐ Movement ☐ Resting ☐ Sleeping ☐ Massage

Worse with: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ Movement ☐ Resting ☐ Sleeping ☐ Working

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing ☐ Localized Tingling ☐ Nausea ☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Headaches: Location: ☐ Occipital ☐ Frontal ☐ Left Temporal ☐ Right Temporal ☐ Parietal ☐ Sinus

Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura

Types: ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension

Other: (frequency/duration/time of day) ____

2: Shoulder, Arm, Wrist, Hand (circle area of concern)

Condition: ☐ New → ☐ Acute or ☐ Chronic Started:________________Last Occurred:________________

☐ Recurrence (Acute) ☐ Exacerbation (Acute) ☐ Chronic

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral ____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting

☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other ______________________________

Level of Pain (At your best):

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

Level of Pain (At your worst):

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

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Context: *Better with:* ☐ Warm Temp ☐ Cold Temp ☐ Medication ☐ Movement ☐ Resting ☐ Sleeping ☐ Massage

Worse with: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ Movement ☐ Resting ☐ Sleeping ☐ Working

3: Upper Back

Condition: ☐ New → ☐ Acute or ☐ Chronic Started:________________Last Occurred:________________

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral ____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting

☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other ______________________________

Level of Pain (At your best):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Level of Pain (At your worst):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
Context: *Better with:* ☐ Warm Temp ☐ Cold Temp ☐ Medication ☐ Movement ☐ Resting ☐ Sleeping ☐ Massage
Worse with: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ Movement ☐ Resting ☐ Sleeping ☐ Working

4: Lower Back

Condition: ☐ New → ☐ Acute or ☐ Chronic Started:________________Last Occurred:________________
Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness
Location: Left / Right / Bilateral ____
Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other ______________________________

Level of Pain (At your best):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Level of Pain (At your worst):
0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
Context: *Better with:* ☐ Warm Temp ☐ Cold Temp ☐ Medication ☐ Movement ☐ Resting ☐ Sleeping ☐ Massage
Worse with: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ Movement ☐ Resting ☐ Sleeping ☐ Working

5: Hip, Knee, Ankle, Foot (*circle area of concern*)

Condition: ☐ New → ☐ Acute or ☐ Chronic Started:________________Last Occurred:________________
☐ Recurrence (Acute) ☐ Exacerbation (Acute) ☐ Chronic
Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness
Location: Left / Right / Bilateral ____
Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other ______________________________

Level of Pain (At your best):

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

Level of Pain (At your worst):

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

Timing: ***Worse:*** ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Context: ***Better with:*** ☐ Warm Temp ☐ Cold Temp ☐ Medication ☐ Movement ☐ Resting ☐ Sleeping ☐ Massage

Worse with: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ Movement ☐ Resting ☐ Sleeping ☐ Working

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Other Assoc Signs and Symptoms:

☐ aches	☐ burning	☐ cold limb(s)	☐ difficulty walking	☐ dizziness
☐ ecchymosis	☐ chronic fatigue	☐ fever	☐ heartburn	☐ joint stiffness
☐ muscle spasm	☐ muscle weakness	☐ nausea	☐ numbness	☐ pale bluish skin
☐ panic	☐ pins & needles	☐ rhinorrhea (runny nose)	☐ shortness of breath	☐ sweating
☐ swelling	☐ tingling	☐ vomiting		

Modifying Factors:

Symptoms Better With:					
	☐ nothing helps	☐ activity	☐ bending	☐ applying cold	☐ applying heat
	☐ massage	☐ movement	☐ OTC meds	☐ Rx meds	☐ rest
	☐ stretching	☐ sitting	☐ standing	☐ twisting	☐ walking

Since condition began, has anything permanently helped you? ☐ **YES** ☐ **NO**

Has anything that you have done, thus far, fixed you problem? ☐ **YES** ☐ **NO**

Employment:

Occupation/Job Title: ____ **Work:** _____ **hrs / day or week**

Description of Work: ____

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)

Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)

Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**

Work Activity Postures: (hrs/day)

☐ bending: _____h/d	☐ climbing: _____h/d	☐ kneeling: _____h/d	☐ pulling: _____h/d	☐ pushing: _____h/d
☐ reaching: _____h/d	☐ sitting: _____h/d	☐ standing: _____h/d	☐ twisting: _____h/d	☐ walking: _____h/d

Repetitive Activities: (hrs/day)

☐ assembly/fine manipulation: _____h/d	☐ computer use/typing: _____ h/d	☐ grasping: _____ h/d
☐ hand tool use: _____ h/d	☐ operation of machinery controls: _____ h/d	☐ phone use: _____h/d

Condition's Effect On Job Performance:

☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited ability) ☐ **Mod/Severe** Limited Duty ☐ **Severe** No Limited Duty ☐ **Severe** (can't do limited duty)

PLEASE FILL THE FOLLOWING EFFECTS ON PERFORMANCE - AS NECESSARY FOR INSURANCE PURPOSES

Unable to perform ... **Able to perform as before**

0 1 2 3 4 5 6 7 8 9 10

Activity											
Pet Care:	0	1	2	3	4	5	6	7	8	9	10
Cleaning:	0	1	2	3	4	5	6	7	8	9	10
Gardening:	0	1	2	3	4	5	6	7	8	9	10
Laundry:	0	1	2	3	4	5	6	7	8	9	10
Repairs:	0	1	2	3	4	5	6	7	8	9	10
Shopping:	0	1	2	3	4	5	6	7	8	9	10
Meal Clean up:	0	1	2	3	4	5	6	7	8	9	10
Iron/folding:	0	1	2	3	4	5	6	7	8	9	10
Meal Preparation:	0	1	2	3	4	5	6	7	8	9	10
Driving:	0	1	2	3	4	5	6	7	8	9	10
Yard Work:	0	1	2	3	4	5	6	7	8	9	10
Childcare:	0	1	2	3	4	5	6	7	8	9	10
Dressing:	0	1	2	3	4	5	6	7	8	9	10
Exercising:	0	1	2	3	4	5	6	7	8	9	10

What Type of exercise do you do?____

Activity											
Carry Groceries:	0	1	2	3	4	5	6	7	8	9	10
Extended Computer Use:	0	1	2	3	4	5	6	7	8	9	10

Walking: ☐ Affected/ Painful ☐ Need Cane ☐ Need Walker ☐ Need Wheelchair

Sitting: ☐ No Effect ☐ Affected/ Painful **How Long Can you sit? ______Hrs/Min**

Standing: ☐ No Effect ☐ Affected/Painful **How Long Can you Stand? ______Hrs/Min**

Sit to Stand: ☐ No Effect ☐ Affected/Painful ☐ Need Assistance ☐ Difficult/Painful ☐ Unable to perform

In/Out of Bed: ☐ No Effect ☐ Affected/Painful ☐ Need Assistance ☐ Difficult/Painful ☐ Unable to perform

Lifting: ☐ No Effect ☐ Affected/Painful **What is the Max Weight Lifted?_____**

Sleeping: ☐ No Effect ☐ Affected Painful/Difficult ☐ Difficulty Falling Asleep ☐ Difficulty turning over

Climb Stairs: ☐ No Effect ☐ Affected/Painful ☐ Affected Going up Stairs ☐ Affected Going down Stairs
☐ Affected Going up & down stairs ☐ Difficult/Painful ☐ Need Railing ☐ Need Assistance

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REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional:	☐ **I DENY having or have had any of the symptoms or problems listed below.**		
☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision:	☐ **I DENY having any of the symptoms or problems listed below.**		
☐ **blindness**	☐ **change in vision**	☐ **field cuts**	☐ **photophobia**
☐ **blurred vision**	☐ **double vision**	☐ **glaucoma**	☐ **tearing**

☐ cataracts ☐ eye pain ☐ itching ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ history of head injury ☐ postnasal drip ☐ tinnitus (ringing in ears)
☐ difficulty swallowing ☐ fainting ☐ hoarseness ☐ rhinorrhea (runny nose) ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections
☐ dizziness ☐ headaches ☐ nasal congestion ☐ snoring

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma ☐ coughing up blood ☐ sputum production
☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort) ☐ high blood pressure ☐ shortness of breath with exertion or exercise
☐ chest pain ☐ low blood pressure ☐ swelling of legs
☐ claudication (leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers
☐ heart murmur ☐ palpitations ☐ varicose veins
☐ heart problems ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain ☐ diarrhea ☐ indigestion ☐ abnormal stool caliber ☐ vomiting blood
☐ belching ☐ difficulty swallowing ☐ jaundice ☐ abnormal stool color
☐ black - tarry stools ☐ heartburn ☐ nausea ☐ abnormal stool consistency
☐ constipation ☐ hemorrhoids ☐ rectal bleeding ☐ vomiting

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control ☐ cramps ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ vaginal discharge
☐ burning urination ☐ hormone therapy ☐ urine retention

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination ☐ frequent urination ☐ prostate problems
☐ erectile dysfunction ☐ hesitancy/ dribbling ☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance ☐ excessive hunger ☐ goiter ☐ unusual hair growth
☐ diabetes ☐ excessive thirst ☐ hair loss ☐ voice changes
☐ excessive appetite ☐ abnormal frequency of urination ☐ heat intolerance

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ paresthesias ☐ varicosities
☐ hair growth ☐ history of skin disorders ☐ rash

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor
☐ facial weakness ☐ loss of consciousness ☐ seizures ☐ stress ☐ unsteadiness of gait
☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ anhedonia
- ☐ anxiety
- ☐ loss or change in appetite
- ☐ behavioral change
- ☐ bi-polar disorder
- ☐ confusion
- ☐ convulsions
- ☐ depression
- ☐ insomnia
- ☐ memory loss
- ☐ mood change

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ anaphalaxis
- ☐ food intolerance
- ☐ itching
- ☐ acute nasal congestion
- ☐ chronic nasal congestion
- ☐ rash
- ☐ sneezing

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ anemia
- ☐ bleeding
- ☐ blood clotting
- ☐ blood transfusion
- ☐ bruising easily
- ☐ fatigue
- ☐ lymph node swelling

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

☐ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. **If yes, Who?** (Name) ______________________

Type of Treatment: ____________________ **Were you satisfied with the results of your treatment?** ☐ Yes ☐ No

Explain: ____

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: ________________________ **Location:** ______________________ **Date of Last Visit:** ___________

Were you satisfied with your care? ☐ Yes ☐ No. **Why?** ____

Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other____________

For how long? _________________________ **Were they prescribed by a doctor?** ☐ Yes or ☐ No.

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: **List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**

	Dosage	For What Condition, if any?	How long have you been taking this?

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? ☐ yes or ☐ no.

***Illness (es):* LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ allergies/hayfever	☐ bedwetting	☐ ear infections	☐ headaches
☐ alzheimers	☐ depression	☐ influenzal pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

***Surgery (ies):* LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental sugery	☐ joint replacement	☐ spinal fusion
☐ cardic catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

***Injury (ies):* Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

***Non-Drug Allergies:* Mark all that apply below.**

☐ adhesive tape	☐ eggs	☐ newsprint	☐ shellfish
☐ animals	☐ feathers	☐ nuts	☐ smoke
☐ bee sting	☐ food coloring	☐ peanuts	☐ soap
☐ chocolate	☐ latex	☐ perfumes	☐ soy

***Family History:* Mark all that apply below. List any specific conditions past or present after has/had:**

father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________________
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________________
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________________
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ____________________
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ____________________
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________________

Social History: Mark all that apply below.

Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink the following regularly (mark below)
☐ beer ☐ liquor ☐ wine; quantity of ________ oz./glasses per ☐ day ☐ week ☐ month

My Dietary Intake consists mainly of the following: (mark all that apply)

☐ high fat	☐ high salt	☐ low fiber
☐ high fiber	☐ low calorie	☐ low salt
☐ high protein	☐ low carbohydrate	☐ low sugar

Tobacco: ☐ Do not use tobacco ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke: # ____ per ☐ Day ☐ Week ☐ Month; ☐ Chew: #______cans per ☐ Day ☐ Week ☐ Year

Disclaimer:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Marshalls Creek Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Marshalls Creek Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor(s) _Brett_ and _Anne Marie Coryell_ to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Copies of X-Rays and medical records are available to me at a fee that can be further discussed with our office employee who handles medical records. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: ____________________________ Patient's Signature: _________________________ Date: ___________
Consent to treat a Minor: _______________________________ Date: ______________
Guardian or Spouse's Signature of Authorizing Care: _________________________________ Date: ______________

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: ____ Date: ______________
Patient's Signature: ____ Date: ______________

Would you like our office to send a copy of your exam reports to your primary care physician?
Yes [ ] No [ ]

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