Valerie E. Girard, D.C.
PATIENT INTRODUCTION

Admitted Date: _____ /_____ /20_____ Info. verified:_____
Date

Patient Name: _____
First Last Middle Maiden

Home Address: _____
Street City State Zip

Phone Numbers: _____ _____ _____
Home Work Cell

Male Female **If female, are you now pregnant? _____no _____yes ….how long?_____**

_____ /_____ /_____ _____
Date of Birth E-mail address

_____ Married _____ Single _____ Divorced _____Widowed Children (ages) _____

Occupation: _____
Patient's Employer:_____
Business Address: _____
Street City State Zip

Purpose for this appointment: _____

_____

Other doctors seen for this condition: _____

Referred by: _____

IN CASE OF EMERGENCY: (Name of relative or friend not living in your home)
Name: _____ Relationship to you: _____

Phone: _____

Address: _____
Street City State Zip

DO YOU HAVE MEDICARE? _____YES _____NO
If you marked "YES," please present your Medicare card to the front desk. Please ask if you need an explanation of Medicare coverage.

DO YOU HAVE GROUP HEALTH INSURANCE? _____YES _____NO If yes, what company?

_____
If you marked "YES," and we are not contracted with your insurance company,you must pay at time of viist. As a courtesy, we will bill for you. If we are contracted with your insurance company, please present your insurance card.

******PLEASE PRINT******

IS THIS CONDITION RELATED IN ANY WAY TO WORK? _____YES _____NO
(**IF YOU MARKED "YES,"** PLEASE NOTIFY THE FRONT DESK FOR STATE-REQUIRED FORMS.)

IS THIS CONDITION RELATED IN ANY WAY TO AN AUTO ACCIDENT OR PERSONAL INJURY? _____YES _____NO

What activities aggravate your condition? _____

Is this condition getting worse? ____Yes ____No ____Constant ____Comes and Goes
Is this condition interfering with your: ____Work ____Sleep ____Daily Routine Other_____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition. _____

What do you believe is wrong with you? _____

List surgical operations and years. _____

Drugs you currently take: ____Nerve pills ____Pain killers ____Muscle relaxers ____"Pep" pills Tranquilizers ____Birth Control pills
Others: _____
Dental visits: ____Every 6 mos.____ Yearly ____Toothache or emergency only ____Complete dentures
Age of mattress _____ ____Comfortable ____Uncomfortable Do you use a bed board? ____Yes ____No
Are you wearing: ____Heel lifts ____Sole lifts ____Inner soles ____Arch supports
Have you been in an auto accident: ____Past year ____Past 5 years ____Over 5 years ____Never
Describe: _____
Have you ever had any mental or emotional disorders? ____Yes ____No If yes, when? _____
Have others in your family had such disorders? ____Yes ____No If yes, when? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weakness, thus information about your family members will provide a better understanding of your total health picture.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	____	____	_____
Used a cane, crutch or other support?	____	____	_____
Been treated for a spine or nerve disorder?	____	____	_____
Had a fractured bone?	____	____	_____
Been hospitalized for other than surgery?	____	____	_____
DO YOU:			
Now take vitamins or minerals?	____	____	_____
Think you may need vitamins or minerals?	____	____	_____
Have an allergy to any drug?	____	____	_____

DATE OF LAST:	Less than 6 months	6-18months	Over 18 months	Never
Spinal exam	____	____	____	____
Physical exam	____	____	____	____
Blood test	____	____	____	____
Chest X-ray	____	____	____	____
Spinal X-ray	____	____	____	____
Dental X-ray	____	____	____	____
Urine test	____	____	____	____

HABITS:	Heavy	Moderate	Light	None	LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS
Alcohol	____	____	____	____	
Coffee	____	____	____	____	
Tobacco	____	____	____	____	_____
Drugs	____	____	____	____	_____
Sleep	____	____	____	____	_____
Appetite	____	____	____	____	_____

NAME: _____ HEIGHT: _____WEIGHT: _____AGE: _____

PLEASE CHECK ONLY THE SYMPTOMS THAT APPLY TO YOU

METABOLOGY

__Abnormal thirst
__Afternoon headaches
__Afternoon yawning
__Brown spots/bronzing of skin
__Burning or itching anus
__Can't work under pressure
__Chronic fatigue
__Daytime sleepiness
__Eat often to alleviate hunger
__Eat often to alleviate faintness
__Get drowsy often
__Get shaky if hungry
__Hard to awaken
__Hunger between meals
__Sex desire low
__Sex desire high
__Low energy
__Pulse speeds after meals
__Perspire easily
__Intolerance to heat
__Irritable before meals
__Irritable if hungry
__Mental sluggishness
__Night sweats cold
__Night sweats hot
__Aversion to drinking water
__Heavy physical labor
__Moderate labor and/or exercise
__Sedentary lifestyle
__Unable to have children due to sterility
__Use very little salt
__Nervous and shaky
__Headaches relieved by eating sweets
__Get hungry 5 minutes after eating
__Wake up at night feeling hungry
__Lowered resistance
__History of boils, leg sores and styes
__Lesions heal slowly
__Cold sweating palms
__Emotional storms cause exhaustion / must lie down
__Feel pick-up after exercising
__Diabetes
__Family member has diabetes
__Hypoglycemia
__Crave sweets, but eating sweets doesn't relieve symptoms
__Food allergies:_____ _____

__Married Children_____ Ages_____
__Living with someone
__Live alone
__Depression
__Anxiety
__PTSD

CIRCULATION

__History of valvular disease
__Nosebleeds
__Small blood vessels showing on cheeks, nose, or ankles
__Unusual redness on palms of hands
__Burning or numb feet
__Ankles swell in evening
__Ankles swell in morning
__Sensitive to cold
__Sensitive to hot
__Dull chest pain or radiating to left arm, worse on exertion
__Eyelids swollen or puffy
__Extremities cold or clammy
__Goosebumps common
__Hands and feet go to sleep
__Heart palpitates-irregular heart beat
__Increased blood pressure
__Low blood pressure
__Pain between shoulder blades
__Pulse below 65
__High cholesterol
__High triglycerides
__Numbness-Where?_____
__Poor circulation
__Rapid heart beat
__Slow heart beat

SENSES

__Motion sickness
__Bloodshot eyes
__Fever
__Inability to adjust eyes when entering a dark room
__Blurred vision
__Body odor
__Cataracts
__Crawling sensation of skin
__Eyestrain
__Flouescent lighting
__Impaired hearing
__Noises in head
__Ringing in ears
__Strong light irritates
__Eye pain
__Earaches

RESPIRATION

__Allergies
__Breathing heavy
__Cigarette cough
__Dizziness or fainting
__High altitude discomfort
__Shortness of breath on exertion
__Sigh frequently
__Wheezing
__Chronic cough
__Spit up phlegm
__Sinus Issues
__Long COVID

PLEASE CHECK ONLY THE SYMPTOMS THAT APPLY TO YOU

TOXICOLOGY

__Silver fillings
__Use aluminum cooking utensils
__Take aspirin
__Bitter metal taste in mouth
__Sensitivity to chemicals in environment
__Convulsions
__Nose or eyes water
__Food poisoning history
__Going crazy sensation
__Frequent hoarseness
__Sneezing attacks
__Heat prostration
__Mold in environment

ELIMINATION / GASTRO-INTESTINAL

__Colitis
__Urine bubbles in bowel
__Frequent hiccoughing
__Stool is yellow or clay colored
__Stool is black
__Stool shows undigested food
__Roughage in diet aggravates diarrhea
__More than 3 bowel movements per day
__Decreased amount of urine
__Immediate bowel movement after eating
__Frequent urination
__Increased urination
__Kidney attacks or stone
__Laxatives used often
__Mucous in stool
__Smelly urine
__Stool floats in bowl
__Stool alternates soft to watery
__Blood in urine
__Puss in urine
__Kidney infection
__Bed wetting
__Intestinal worms now or in the past
__Liver trouble
__Hemorrhoids
__Jaundice
__Nausea
__Pain over stomach
__Reflux
__Vomiting
__Vomiting of blood
__Constipation
__Bloating / gas

MALES ONLY

__Night urination frequent
__Prostrate trouble
__Feeling of incomplete bowel evacuation
__Impotency

STRUCTURAL PROBLEMS

__Acne
__Bleeding gums
__Brittle fingernails
__Bruise easily
__Cuts heal slowly
__Damp weather causes discomfort
__Dandruff
__Jaw pain, clicking in jaw
__Dry mouth, nose and eyes
__Dry, scaly skin
__Falling hair after colds or infection
__Joint stiffness in the morning
__ Joint stiffness in the evening
__Low back pains
__Muscle cramps during the day
__Muscle cramps at night
__Charley horses during exercise
__Splitting nails
__Frequent nose bleeds
__Pyorrhea (gum inflammation)
__Skin cracks / peels on soles of feet
__Fungal infection / Athlete's foot
__Sebaceous cysts on scalp
__Frequent skin rash
__Stiff neck
__Sunburn easily
__Trouble with gums
__Hair breaks easily
__Wear dentures
__Nails dry and brittle
__Hangnails
__Swollen joints
__Hernia
__Spinal curvature
__Muscle stiffness in morning
__Corners of mouth cracked
__Dry irritated nostrils
__Chapped lips, hands, etc.
__Fever blisters
__Prematurely grey
__Water blister on scalp
__Oily hair
__Dry hair
__Hair has high static electricity
__Warts
__Slow hair growth
__Slow nail growth
__Varicous veins
__Bursitis

PLEASE CHECK ONLY THE SYMPTOMS THAT APPLY TO YOU

STRUCTURAL PROBLEMS (CONT.)

__Foot trouble
__Painful tail bone
__Poor posture
__Sciatica
Pain (P) or Numbness (N)
__Elbows __Hands __Ribs
__Hips __Legs __Shoulders
__Knees __ Feet __Arms

FEMALES ONLY

__History of vaginal infections. Type:_____
__History of bladder infections
__Discoloration due to birth control pill
__Facial hair
__Easily fatigued
__Premenstrual tension
__Depression prior to menstruation
__Menses excessive or prolonged
__Painful breasts
__Vaginal discharge
__Menopausal hot flashes
__Menses scanty or missed
__Acne worse at menses
__Take the pill. How long?_____
__Complete hysterectomy
__Partial hysterectomy
__IUD use
__Uterine fibroids
__Toxemic pregnancy
__Abortion. Date(s): _____
__Miscarriage
__Still birth
__History of pelvic inflammatory disease
__Cramps or backache
__Lumps in breast
__Painful menstruation
__Long menstrual cycle
__Short menstrual cycle
__Irregular cycle
__Heavy menstrual flow
__Light menstrual flow

HAVE YOU EVER HAD:

__Alcoholism
__Anemia
__Appendicitis
__Arteriosclerosis
__Arthritis
__Cancer
__Chemical poisoning
__Chicken pox
__Chorea
__Cold Sores
__Diphtheria
__Drug reaction
__Eczema
__Emphysema
__Epilepsy
__Long Flu
__Goiter
__Gout
__Heart attack
__Herpes
__Measles
__Obesity
__Pleurisy
__Pneumonia
__Polio
__Rheumatic fever
__Mumps
__Stroke
__Tuberculosis
__Typhoid fever
__Ulcers
__Venereal disease
__Whooping cough
__Hepatitis
__Epstein-Barr Virus
__COVID
__Parasites
__Other (please specify)

_____

Do you crave: ____Sweets ____Coffee ____Cola ____Salt ____Spices ____Chocolate ____Fats ____Starches

PLEASE LIST ANYTHING ELSE YOU WANT US TO BE AWARE OF:

_____
_____
_____
_____

QUADRUPLE VISUAL ANALOGUE SCALE

Name: _____Age_____Date_____

INSTRUCTIONS: Please circle the number which best answers the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

EXAMPLE:

			headache		neck					low back	
No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable pain

1) What is your pain **RIGHT NOW**?

No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable pain

2) What is your **TYPICAL** or **AVERAGE** pain?

No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable pain

3) What is your pain **AT ITS BEST** (How close to "0" does your pain get at its best?)

No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable pain

4) What is your pain **AT ITS WORST** (How close to "10" does your pain get at its worst?)

No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable pain

5) What percentatge of the day is your pain at its worst?

Dr. Valerie Girard

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

As with any healthcare procedure there are certain complications, which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note: some patients may experience some stiffness or soreness following the first few days of treatment. Other complications, however rare, may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costo-vertebral strains.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone and tissue, which I check for during the history, examination and film studies, when warranted. I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

Some forms of manipulation have been associated with injuries to the arteries of the neck, which, in very rare cases, could contribute to a stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of this extremely remote chance.

I will make every effort to screen for any contraindication to care. However if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

I do not expect the doctor to be able to anticipate and explain all risks and wish to rely on the chiropractor to exercise judgment during the course of treatment, which the doctor feels at the time, based on facts then known, is in my best interest. I consent to the doctor's visual observation of any body parts that may be in pain. I also consent to the use of the Activator to correct the alignment of the body and relieve pain, as well as the use of the cold laser when warranted. I consent to the doctor's touching my physical body for the purposes of a physical and orthopedic examination. In addition I consent to the doctor testing muscles for soreness, strength and abnormality. The doctor has my permission to make both manual and non-force alignments for the purpose of reducing pain and aligning the body.

I also acknowledge that even as the doctor has made every precaution in creating a safe environment, COVID-19 has a long incubation period and is very contagious. It is impossible to determine who has COVID-19, given the current limits on testing.

I have read the above consent. I have also had an opportunity to ask questions about its content and about the nature of the proposed treatment. I understand and accept the risks related to chiropractic treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ Patient Signature _____Print Name

_____ Witness Signature _____ Date

Responsibility for Payment:
Payment is expected at the time of the visit. Insurance and Medicare will be billed for the patient with payment being sent directly to the patient.

_____
Initial

A notice of at least Four hours is required for canceled appointments. I understand that my account will be charged ($45.00) if this policy is not adhered to, and I agree to pay these charges. Please call the night before when canceling early morning appointments.

_____
Initial

I understand regardless of my payment method, any orthopedic supports, nutritional supplements I purchase must be paid in full. These items will not be charged to my account or billed to the insurance company.

I hereby authorize the release of my medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to me or to my dependents, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office 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 this chiropractic office will be credited to my account upon receipt.

X_____ _____
Signature (If patient is a minor, parent or legal guardian Date