Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT IANNELLI WELLNESS CENTER

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Circle one: Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Home Phone: _____

Marital Status (Please circle one): Single Married Divorced Widowed Cell Phone: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

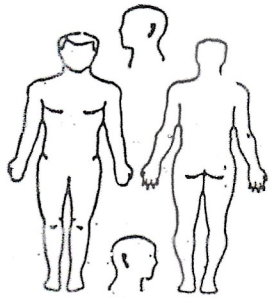
Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Forth complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Please Mark an "X" on the diagram to describe where your symptom areas are. →



When did the problem(s) begin? _____ When is the problem at its worst? ☐AM ☐ PM ☐ Mid-day ☐ All day

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated in the past (Circle one)? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ N/A

What relieves your symptoms? _____ What makes them feel worse? _____

Height:_____ Weight:_____ Last Known Blood Pressure:_____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No **If yes**, how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: Yes No **If yes**, what type of treatment? _____

Who provided it: _____ **How long ago?** _____ What were the results? ☐ Favorable ☐ Unfavorable →

Please explain. _____

Please indentify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for the **Past** and a **C** for **Currently**:

____Broken Bone ____Dislocations ____Tumors ____Rheumatoid Arthritis ____Fracture ____Disability

____Heart Attack ____Osteo Arthritis ____Diabetes ____Cerebral Vascular ____Cancer ____Other:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY (Circle those that apply to you)

1. Smoking: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never

2. Alcoholic Beverage: consumption occurs → Daily Weekends Occasionally Never

3. Recreational Drug Use: _____ → Daily Weekends Occasionally Never

4. Hobbies–Recreational Activities–Exercise Regime: How does your present problem affect the following, See Activities of Life

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No **If yes, whom**: _____

2. **Any** other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Iannelli Wellness Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Iannelli Wellness Center for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature **Date**

Activities of Daily Living/Symptoms/Medications

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out routine activities

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Recreation Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ unable to perform

INFORMED CONSENT FOR CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT

Chiropractic treatment primarily involves the manual manipulation of the treated area using the chiropractor's hands or mechanical devices. During treatment, you may experience sensations like clicks, pops, and movement. Additionally, our office may utilize various modalities in your care, as recommended by your chiropractor based on their professional judgment.

POSSIBLE RISKS

Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slightly increased pain in the treated area, possibly due to minor muscle, tendon, or ligament strain. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

It's important to note that serious bodily harm is extremely rare and not an inherent risk of chiropractic treatments. Various factors can influence one's health, including prior injuries, medications, and underlying medical conditions like osteoporosis, cancer, and other illnesses. When such conditions are present, chiropractic treatment may carry the risk of serious adverse events, including fractures, dislocations, or the exacerbation of previous injuries to ligaments, intervertebral discs, nerves, or the spinal cord. It's essential for patients to remain vigilant and seek medical and/or chiropractic care if they experience symptoms suggestive of stroke or cerebrovascular injury. Your chiropractor is well-informed about this association and will assess for relevant symptoms when appropriate. It is imperative to disclose your full medical history, including medications, surgeries, and all relevant health conditions like osteoporosis, heart disease, cancer, stroke, fractures, or prior severe injuries.

OTHER OPTIONS FOR THE TREATMENT OF PAIN INCLUDE

Apart from chiropractic care, alternative approaches to managing pain include doing nothing and living with it, over-the-counter medications, physical therapy, medical interventions, injections, or surgery. There is a multitude of pain management options, each carrying potential benefits and risks. We encourage you to ask any questions you may have about the potential risks associated with chiropractic treatment.

I, the undersigned, confirm that I have read and understood the information provided above, including the potential risks associated with chiropractic treatment, and have had the opportunity to inquire about any concerns I may have. I have disclosed my relevant medical history, as well as any conditions that have previously caused me pain.

Patient Name	Signature	Date