Body-Mind-Health

Rosemarie Cartagine, DC, MSACN, CNS

Your First Visit

Patient Forms

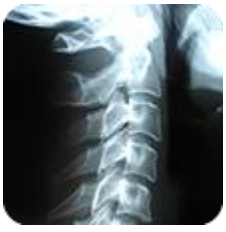
Upon entering our office our chiropractic assistant will greet you and welcome you as a member of our practice. We will request that you fill our new patient forms in our office upon your arrival. The paperwork provides us with general information about yourself and your condition. All your information is strictly confidential.

Consultation

Next you will have a consultation with Dr. Rosemarie Cartagine to discuss your health-related problems and concerns, as well as potential treatment options. Your first visit is designed for Dr. Cartagine to learn more about you, your current condition, your health history, and your expectations to determine whether chiropractic care will you meet your goals.

Examination

After your consultation, Dr. Rosemarie Cartagine will perform a complete chiropractic examination which includes testing your reflexes, your ability to turn and bend as well as other standard neurologic, orthopedic, postural, and physical examinations. Nothing will be done in our office without your consent.



X-Ray Studies

Your specific condition may require us to order x-rays or other imaging to get a full evaluation of your spine. Imaging helps us rule out more serious conditions or assists us in developing the most effective treatment plan for you. Most people are amazed once they see their x-rays and can often immediately identify their misalignments and degeneration themselves.

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Your Second Visit

Report of Findings

Once all your consultation and examinations have been reviewed and analyzed, Dr. Cartagine will give you a report of findings to answer the three most popular questions:

1. Can you help me?
2. What do you recommend that I do to get better?
3. How much is it going to cost?

After discussing your history and goals with you along with the examination and imaging results, Dr. Cartagine will personally review her recommendations with you. If you have a condition that requires care with other providers, the doctor will tell you. If Dr. Cartagine believes she can help you, she will recommend treatment and a wellness program.

Treatment

Patients will generally be provided with their first treatment after the report of findings. This may include spinal adjustments, and/or soft tissue therapies such as craniosacral therapy or myofascial release. Treatment is gentle, and you can express any concerns you have about any of the techniques. Most patients feel a sense of ease and wellbeing after a treatment.

Wellness Program

Additionally, patients will be instructed on a home care healing and wellness program. If you are in pain when you first come into our office this may include ice or heat application instructions, nutritional suggestions, avoidance of certain activities or positions, as well as home exercises and/or stretches. If you desire an overall wellness lifestyle, we will work with you to create good habits and routines that support your success. Everybody is unique and different and therefore everyone requires a unique and customized wellness plan. The foundation of our overall wellness lifestyle is maintaining healthy posture and good spinal alignment, eating a healthy diet, taking supplements, keeping your weight under control and stress relief.

We positively change lives.

www.CartagineChiropractic.com

Body-Mind-Health

Dr. Rosemarie Cartagine

Patient Introduction

Your Name: _____
First Middle Last

Your Address:

_____

_____

Telephone: Home:_____ Mobile: _____

E-mail: _____

Emergency Contact (Relationship) _____Phone: _____

Birth Date: _____ Marital Status:_____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:

_____

Primary Care Physician: _____

Address/Phone: _____

Referred to our office by: _____

Thank you!

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Dr. Rosemarie Cartagine

Adult Consultation History

Your Name: _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

When and how did it begin? _____

Have you ever experienced the same or similar symptoms? _____

What makes your symptoms better? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

Have you become discouraged about handling this problem? _____

_____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel: _____

What gives you some temporary relief? _____

What is the pattern of this problem?
Constant _____ Intermittent _____ Occasional _____ Cyclic _____

Types of pain?
Dull___Stiff___Sore____Tight____Sharp____Burn___Throb___Shooting___Numbness____

Pins & Needles____ Tingling____ Where? _____

Rate pain range on a scale of 1 – 10 (zero is no pain, 10 is excruciating) _____

How does this problem effect your body functions? _____

Are you on any type of medication?_____ Please list all: _____
_____

Do you take vitamins, supplements or herbs? _____ Please list all: _____
_____

Have you had any surgeries? _____ Please list:
_____
_____

Have you had prior physical, or emotional traumas, accidents, falls, or injuries?_____

If yes, please give us the details: _____
_____

Have you been involved in an auto accident? _____ Date of accident: _____

Do you have any difficulties from this? _____

Do you smoke? ____Consume alcohol? ____ Consume caffeine? ___Do you exercise? ____

If yes, how often and what activities? _____

How would you rate your overall level of stress? High ____ Moderate ____ Minimal _____

Do you have any children? _____

Is there any other information you would like us to know?_____
_____
_____

SIGNATURE: _____ DATE: _____

Thank You!
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Dr. Rosemarie Cartagine

Initial Child & Adolescent Questionnaire

Child's Name: _____ Date of Birth: _____

Parent(s) name(s): _____ _____

Mainly for Birth Moms:

1. Tell us about the pregnancy:

Was the baby carried to full term? _____

Describe any complications and when they occurred: _____
_____
_____

2. Tell us about the delivery and birth of this child:

Did you/she use a midwife? _____ Home or Hospital birth? _____
Obstetrician? _____
Was birth by a C-Section? _____ Were forceps used? _____
Vacuum Extraction? _____ Was delivery induced? _____
Was an epidural given? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did the baby breastfeed? _____ How long? _____ What formula after? _____

Was alcohol consumed alcohol pregnancy? _____ How much? _____
Did mom smoke? _____ How much? _____ How long? _____

Were any medications taken during pregnancy? _____
For what? _____ What type? _____

Any exposures to ultrasound?_____ How many? _____

4. As a baby/toddler (birth to 4 years) did any of the following occur?

___ Fall from changing table
___ Tumble downstairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in "Jolly Jumper"
___ Frequent ear infections
___ Tonsillitis
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight

___ Reaction to vaccination ___ Other_____

Please explain the above: _____
_____
_____

5. As a young child (5-12 years) did any of the following occur?

___ Fall from a tree	___ Bed wetting
___ Fall off a bicycle	___ Hyperactivity/Autism
___ Fall off playground equipment	___ Learning difficulties
___ Sports accident	___ Asthma
___ Car accident	___ Allergies
___ Stomach pains	___ Leg/knee pains
___ Scoliosis	___ Other_____

Please explain the above: _____
_____
_____

6. Tell us about any vaccinations your child has had: _____
_____
_____

Are you aware of any reactions to any of these? _____
_____

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pains	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ Growing Pains
___ Fatigue	___ Weight gain/loss	___ Other _____

Please explain any of the above: _____
_____
_____

8. Which of the problems you have checked off is the worst? _____
_____

Is this problem: Constant ___ Intermittent ___ Occasional ___ Cyclic ___

9. How long has it persisted? _____

10. When it is at its worst, how does it make your child feel? _____
_____

11. What have you done about it that has NOT worked? _____
_____

12. What makes it worse? _____
_____

13. What effect does this problem have on your child's body functions?
_____
_____

On his/her participation in daily activities? _____

14. **Describe any hospital stays:** _____
_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____
_____

16. **List any medications or vitamins your child is currently taking:**
_____
_____

17. **To summarize, what is your purpose for this appointment?** _____
_____
_____
_____

18. **Is there anything else you feel we should know?** _____
_____
_____
_____

I hereby authorize Dr. Rosemarie Cartagine to examine and/or treat my child.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

Thank you!

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