CONFIDENTIAL PATIENT INFORMATION

Patient ID #: _____

First Name: _____ MI: _____ Last Name: _____ Sex: ☐ Male ☐ Female

Age: _____ DOB: _____ Marital Status: ☐S ☐M ☐D ☐W Name of Spouse: _____

Home Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____ _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone _____

Whom may we thank for referring you to our office: _____

Purpose of this appointment: _____

_____

How did the problem start? ☐Suddenly ☐Gradually ☐Post-Injury ☐Other: _____

Is this condition: ☐Getting worse ☐Improving ☐Intermittent ☐Constant ☐Other: _____

List all medications or drugs you are currently taking? _____

Have you seen other doctors for this condition? ☐Yes ☐No Doctor's Name: _____

Have you ever received Chiropractic care before? ☐Yes ☐No Doctor's Name: _____

How long under care? _____ Date of last visit: _____ Why did you stop? _____

_____

Have you ever had any significant falls, surgeries, or other injuries as an adult? ☐Yes ☐No If yes, please explain: _____

_____

_____

Notable childhood injuries? ☐Yes ☐No If yes, please explain: _____

_____

Any auto accidents? ☐Yes ☐No If yes, please explain: _____

_____

Remarks and additional information: _____

_____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Patient's Signature _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Information Taken By: _____ Date: _____

SYMPTOM SURVEY

Please check (X) all present symptoms
RATE YOUR PAIN ON A SCALE OF 1-10 FOR EACH SYMPTOM

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temple
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

- ☐ NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ forward
  - ☐ backward
  - ☐ turn to left right
  - ☐ bend to left right
- ☐ Pinched nerve in neck
- ☐ Grinding sounds in neck
- ☐ Muscle spasms in neck
- ☐ Popping sounds in neck

SHOULDERS:
- ☐ Pain in shoulder joint R L
- ☐ Pain across shoulders
- ☐ Can't raise arm R L
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder R L

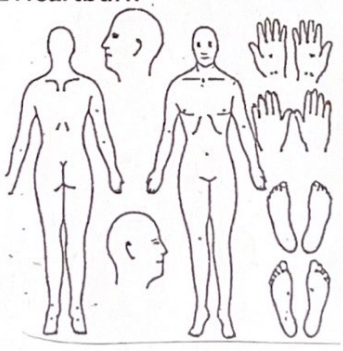
WOMEN ONLY:
- ☐ Menstrual problems
- ☐ Hysterectomy

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ "Pins & needles" in arms
- ☐ "Pins & needles" in fingers
- ☐ Numbness in arms R L
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location_____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn



Color areas of pain on diagram ⇒

LOW BACK:
- ☐ Low back pain
- ☐ Hip
- ☐ Low back pain is worse when
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms

HIPS, LEGS, FEET:
- ☐ Pain in buttocks R L
- ☐ Pain in hip joints R L
- ☐ Pain down leg R L
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ inside
  - ☐ outside
- ☐ Leg cramps
- ☐ Cramps in feet R L
- ☐ "Pins & needles" in legs R L
- ☐ Numbness of leg R L
- ☐ Numbness of feet R L
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles R L
- ☐ Swollen feet R L

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Other_____
- ☐ Diabetes/Hypoglycemia

PATIENT NAME:

_____ Date_____

OUR MISSION IS TO PROVIDE THE HIGHEST QUALITY AND AFFORDABLE CHIROPRACTIC CARE. WITH DEDICATION, WE PROMOTE A BETTER QUALITY OF LIFE.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: *to locate, analyze, and correct spinal interference to the nervous system (nerve pressure)*. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (*spinal misalignment producing nerve interference),* in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustment and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that is known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. 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.

I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

Patient's Signature: _____ **Date:** _____

Guardian/Spouse's Signature: _____ **Date:** _____

Indicate relationship to patient: _____

FEMALES ONLY

Are you pregnant? Y N

If x-rays are recommended, your signature is required (below) to indicate that you are NOT pregnant.

Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, including but not limited to, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____