

PLEASE PRINT

NAME: _____ DATE: _____

DOB: _____

HISTORY OF THE PRESENT ILLNESS / INJURY

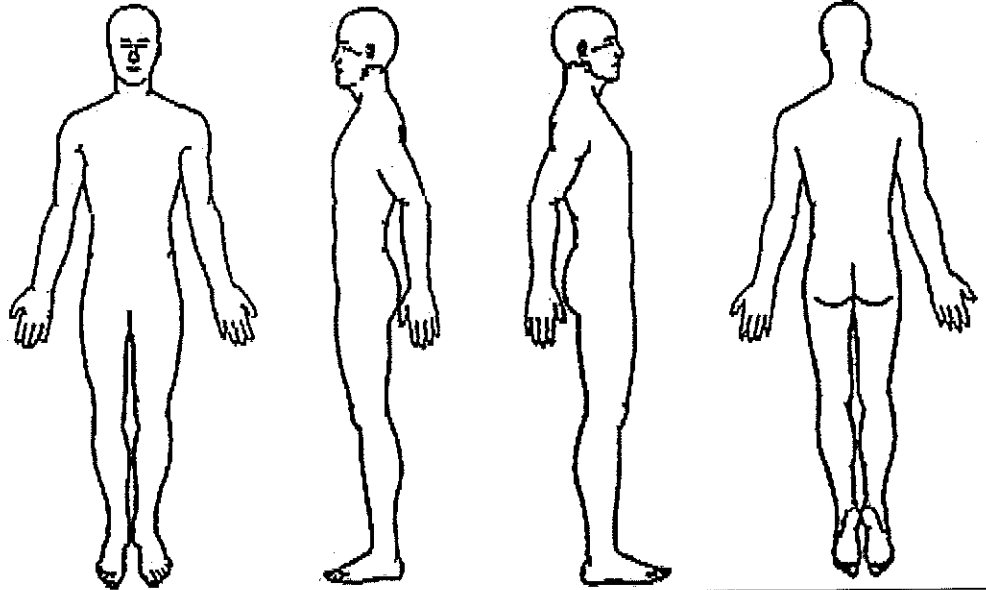
PLEASE BE SPECIFIC:

CHIEF COMPLAINT

BE SURE TO FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOLS. IF THERE IS MORE THAN ONE AREA OF DISCOMFORT, PLEASE RATE THE PAIN ON A SCALE OF 0 TO 100 NEXT TO EACH AREA, WITH 0 BEING NO PAIN AND 100 BEING THE INTOLERABLE PAIN.

- XXX BURNING (BU)
- ((((ACHING PAIN (AC)
- 000 PINS & NEEDLES (PI)
- NUMBNESS (NU)
- ::: SHARP PAINS (SH)

FOR OFFICE USE ONLY	
_____	CONSTANT
_____	COME / GO
_____	GETTING BETTER
_____	GETTING WORSE
_____	STAYING SAME
BETTER:	WORSE:
_____	AM _____
_____	MIDDAY _____
_____	PM _____



WHAT MAKES THE CONDITION BETTER?	WHAT MAKES THE CONDITION WORSE?
HEAD / NECK _____	HEAD / NECK _____
MID BACK _____	MID BACK _____
LOW BACK _____	LOW BACK _____
SHOULDER, ARM, HAND _____	SHOULDER, ARM, HAND _____
HIP, LEG, FOOT _____	HIP, LEG, FOOT _____
OTHER _____	OTHER _____

SYMPTOMS DEVELOPED FROM: WORK-RELATED INJURY AUTO ACCIDENT OTHER

WHEN DID THEY BEGIN? _____ HOW DID IT OCCUR? _____

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THESE CODES:

- | | | | | | |
|-------------------------------------|------------------------|-----------------------------|---------------------------------------|------------|-------------------|
| U – UNABLE | L – LIMITED | P – PAINFUL | D – DIFFICULT | N – NORMAL | H – HAVEN'T TRIED |
| 1. _____ LYING ON BACK | 6. _____ GRIPPING | 11. _____ PUSHING | 16. _____ WALKING SHORT DISTANCE | | |
| 2. _____ LYING ON SIDE W/KNEES BENT | 7. _____ REACHING | 12. _____ KNEELING/STOOPING | 17. _____ STANDING MORE THAN ONE HOUR | | |
| 3. _____ GETTING IN/OUT OF CAR | 8. _____ PULLING | 13. _____ REACHING OVERHEAD | 18. _____ LOOKING UP / DOWN | | |
| 4. _____ UP OR DOWN STAIRS | 9. _____ DRESSING SELF | 14. _____ SITTING | 19. _____ COUGH / SNEEZE / GRUNT | | |
| 5. _____ TURNING OVER IN BED | 10. _____ BALANCING | 15. _____ BENDING FORWARD | HOW? _____ WHERE? _____ | | |

YES NO

DOES THE PAIN INTERFERE WITH YOUR SLEEP?

HOW MANY TIMES DO YOU WAKE UP? _____

DURING THE TIME YOU ARE AWAKE WHAT PERCENTAGE DO YOU EXPERIENCE THESE SYMPTOMS? _____



CONFIDENTIAL PATIENT HEALTH RECORDS

PRINT PATIENT NAME: _____ DATE: _____

AS THEY APPLY TO YOU

QUESTIONS FOR HEADACHES

- YES NO DO YOU EXPERIENCE:
- NAUSEA, VOMITING, DIZZY/BLURRED VISION?
- PAIN EXACERBATED BY LIGHT / NOISE / SMELL?
- IS THE PAIN CONSISTENT?
- DIFFICULTY WITH FOCUS/THINKING?
- HOW LONG DO YOUR HEADACHES LAST? _____
- HOW OFTEN DO THEY OCCUR? _____
- DESCRIBE THE PAIN (ACHE / THROB / PRESSURE): _____
- BECAUSE OF MY HEADACHES, I FEEL RESTRICTED IN PERFORMING MY ROUTINE DAILY ACTIVITIES:
- NOT AT ALL
- SLIGHTLY
- MODERATELY
- VERY MUCH
- EXTREMELY

QUESTIONS FOR LUMBOSACRAL SPINE (LOW BACK)

- YES NO
- FEELING OF SHARP OR SHOOTING PAIN?
WHERE? _____
- DOES PAIN RADIATE TO THE ABDOMEN/GROIN?
- CHANGE OF BOWEL OR URINARY FUNCTION?
(DIARRHEA/CONSTIPATION)
- EXPLAIN: _____
- HOW MUCH HAS YOUR BACK PAIN INTERFERED WITH YOUR DAILY ACTIVITIES (HOUSEWORK, DRESSING, WALKING, CLIMBING STAIRS, GETTING IN & OUT OF BED/CHAIR, ETC.)
- NOT AT ALL
- SLIGHTLY
- MODERATELY
- VERY MUCH
- EXTREMELY

QUESTIONS FOR CERVICAL (NECK) THORACIC (UPPER BACK) SPINE

- YES NO
- NECK CONDITION THAT AFFECTS HEARING, VISION, BALANCE, OR CAUSES RINGING IN EARS?
- DO YOU HEAR GRATING SOUNDS WITH NECK MOTION?
- YES NO
- DIFFICULTY TURNING HEAD? RIGHT LEFT
- PAIN / PRESSURE BEHIND EYES?
- FEELING OF SHARP OR SHOOTING PAIN?
WHERE? _____
- HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR DAILY ACTIVITIES (HOUSEWORK, DRESSING, LIFTING, READING, DRIVING, ETC)
-
- NOT AT ALL SLIGHTLY MODERATELY VERY MUCH EXTREMELY

ANY CHANGES OR UPDATES IN YOUR MEDICAL HISTORY SINCE YOUR LAST UPDATE? (INCLUDE ALL MEDICATIONS, SURGERIES, SUPPLEMENTS, DIAGNOSIS, ETC.) YES NO

ADDITIONAL COMMENTS:

OFFICE USE ONLY:

AGE: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____



INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFORE, IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULLY INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTIONS, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE – STROKE IS THE MOST SERIOUS POTENTIAL COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN IT OCCURS, IT MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS, DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHIN THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT BETWEEN 1 PER 400,000 TREATMENTS TO 1 PER 5.8 MILLION TREATMENTS. USING DATA FROM TWO OF THE LARGEST CHIROPRACTIC INSURERS, THE RISK OF SERIOUS ARTERIAL STROKE SYNDROMES IS SHOWN TO BE LESS THAN 1 IN 2 MILLION TO 1 IN 3.8-5.8 MILLION CERVICAL MANIPULATIONS. THE MOST COMMON TYPE OF VASCULAR LESION WITH THIS ASSOCIATION IS A DISSECTION OF THE VERTEBRAL ARTERY (VBA). (*CURRENT CONCEPTS: SPINAL MANIPULATION AND CERVICAL ARTERIAL INCIDENTS, 2005.*) A 2008 STUDY IN SPINE JOURNAL STATES: "WE FOUND NO EVIDENCE OF EXCESS RISK OF VBA STROKE ASSOCIATED WITH CHIROPRACTIC CARE COMPARED TO PRIMARY CARE." THEREFORE THE RISK IS THE SAME NO MATTER WHOM YOU CHOOSE TO SEE.

SORENESS – CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST-TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IT IS GENERALLY NOT DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY – OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY – MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS TAKING PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES DEEMED "AT-RISK." TREATMENT IS PERFORMED CAREFULLY AND GENTLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS – HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS – THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE INDEED RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS OUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL BEST ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GAVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE: _____ DATE: _____

C.T. SIGNATURE: _____ DATE: _____

D.C. SIGNATURE: _____ DATE: _____