Correction Creek CHIROPRACTIC CENTRE LLC

CONFIDENTIAL PATIENT HEALTH RECORDS

NEW PATIENT

PLEASE PRINT IN PEN

DATE: _____

NAME: _____ HOME PHONE: _____

STREET ADDRESS / P.O. BOX: _____ WORK PHONE: _____

CITY / STATE / ZIP: _____ BIRTHDATE: _____

WHO REFERRED YOU? _____ EMPLOYER: _____

CELLPHONE # & CARRIER: _____ E-MAIL: _____

SPOUSE'S NAME / CONTACT #: _____ SPOUSE'S EMPLOYER: _____

NAMES / AGES OF CHILDREN AT HOME: _____

WHO SHOULD WE NOTIFY IN AN EMERGENCY? _____ RELATIONSHIP: _____ PHONE #: _____

HISTORY OF THE PRESENT ILLNESS / INJURY

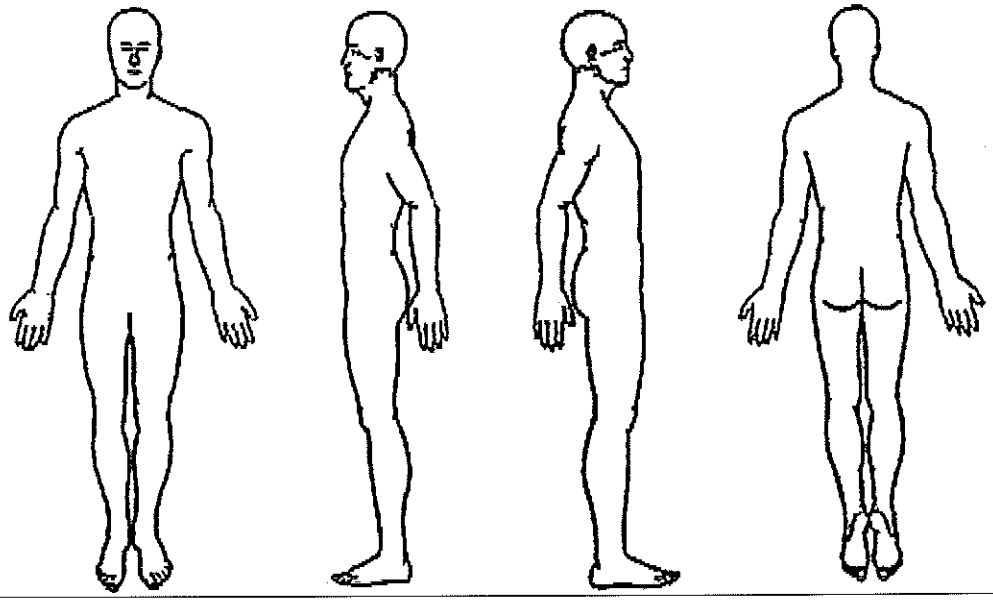
PLEASE BE SPECIFIC:

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 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	_____



NO PAIN — PAIN SCALE: — INTOLERABLE

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

WHAT MAKES THE CONDITION BETTER?

HEAD / NECK _____
MID BACK _____
LOW BACK _____
SHOULDER, ARM, HAND _____
HIP, LEG, FOOT _____
OTHER _____

WHAT MAKES THE CONDITION WORSE?

HEAD / NECK _____
MID BACK _____
LOW BACK _____
SHOULDER, ARM, HAND _____
HIP, LEG, FOOT _____
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	17._____ STANDING MORE THAN ONE HOUR
3._____ GETTING IN/OUT OF CAR	8._____ PULLING	13._____ STOOPING	18._____ BALANCING
4._____ CLIMBING STAIRS	9._____ DRESSING SELF	14._____ SITTING AT TABLE	19._____ COUGH / SNEEZE / GRUNT
5._____ TURNING OVER IN BED	10._____ SLEEPING	15._____ BENDING FORWARD	HOW?_____ WHERE?_____

PRINT PATIENT NAME: _____ DATE: _____

YES	NO		YES	NO	
☐	☐	DOES THE PAIN INTERFERE WITH YOUR SLEEP?	☐	☐	DOES COLD AFFECT THE PAIN?
		HOW MANY TIMES DO YOU WAKE UP?_____			HOW?_____
		WHAT POSITION DO YOU SLEEP IN?_____	☐	☐	DO YOU WEAR A HEEL LIFT?
☐	☐	DOES HEAT AFFECT THE PAIN?			IF SO, WHICH SIDE?_____
		HOW?_____			

PLEASE FILL OUT THE NEXT THREE SECTIONS

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?

HOW LONG DO YOUR HEADACHES LAST?_____

HOW OFTEN DO THEY OCCUR? _____

DESCRIBE THE PAIN (ACHE / THROB / PRESSURE):_____

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: _____

QUESTIONS FOR CERVICAL SPINE (NECK)

YES	NO		YES	NO	
☐	☐	NECK CONDITION THAT AFFECTS HEARING,	☐	☐	DIFFICULTY TURNING HEAD? ☐ RIGHT ☐ LEFT
		VISION, BALANCE, OR CAUSES RINGING IN EARS?	☐	☐	PAIN / PRESSURE BEHIND EYES?
☐	☐	DO YOU HEAR GRATING SOUNDS WITH NECK MOTION?	☐	☐	FEELING OF SHARP OR SHOOTING PAIN? WHERE? _____

PAST MEDICAL HISTORY

HOW MANY TIMES HAVE YOU HAD THE CONDITION THAT YOU ARE SEEING US FOR TODAY? ☐ 0-3 TIMES ☐ 4 OR MORE TIMES.

YES	NO	
☐	☐	HAVE YOU BEEN DIAGNOSED WITH ANY CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US? (DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ASTHMA, IBS/COLITIS, CANCER ETC.) other _____
☐	☐	HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?

DATE	DR. NAME	CONDITION	RESULTS
1.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS
2.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS

☐ ☐ HAVE YOU EVER SEEN A DOCTOR FOR THIS CONDITION?

DATE	DR. NAME	CONDITION	RESULTS
1.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS

☐ ☐ ALLERGIES? TO WHAT? _____

☐ ☐ DO YOU NOW TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

☐ PATIENT WAS ASKED TO BRING IN MEDICATION LIST ☐ SEE ATTACHED MEDICATION LIST

PRODUCT/DRUG	REASON
1.	
2.	
3.	

☐ ☐ HAVE YOU EVER HAD MAJOR ILLNESSES, INJURY, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, OR SURGERIES?

DATE	DR. NAME	CONDITION	RESULTS
1.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS
2.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS
3.			☐ COMPLETE RECOVERY ☐ COMPLICATIONS

Correction Creek Chiropractic Centre

PRINT PATIENT NAME: _____ DATE: _____

SOCIAL HEALTH HISTORY

STATUS: ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER: _____ ☐ STUDENT ☐ FULL-TIME ☐ PART-TIME

OCCUPATION: _____

WORK HOURS PER WEEK: _____ RECREATIONAL ACTIVITIES (HOBBIES): _____

YES	NO		
☐	☐	HOW MUCH WATER DO YOU DRINK? _____	
☐	☐	DO YOU EXERCISE? SPECIFY: _____	TIMES PER WEEK? _____
☐	☐	ARE YOU A TOBACCO USER? SPECIFY: _____	PACKS PER DAY? _____
☐	☐	DO YOU CONSUME CAFFEINE? SPECIFY: _____	HOW MUCH PER DAY? _____
☐	☐	DO YOU CONSUME ALCOHOL? SPECIFY: _____	HOW MUCH PER DAY? _____

FEMALES: ARE YOU PREGNANT? YES ☐ NO ☐ DUE DATE: _____

FAMILY HEALTH HISTORY

HEALTH STATUS OF FAMILY MEMBERS. (IF DECEASED, FROM WHAT?)

MOTHER: _____

FATHER: _____

SISTERS: _____ HOW MANY? _____

BROTHERS: _____ HOW MANY? _____

CHILDREN: _____ HOW MANY? _____

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES AND N FOR NO IN EACH OF THE FOLLOWING)

_____ EYES (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC)

_____ EARS, NOSE, MOUTH, THROAT (HEARING LOSS, SINUS, ETC)

_____ CARDIOVASCULAR (HEART, HIGH BP, HIGH CHOLESTEROL, ETC)

_____ RESPIRATORY (LUNGS, BREATHING, ASTHMA, COPD, ETC)

_____ NEUROLOGICAL (NERVE ISSUES, WEAKNESS, NUMBNESS, ETC)

_____ ENDOCRINE (THYROID, HORMONAL, IMBALANCES, LIVER, ETC)

_____ GASTRO-INTESTINAL (ACID REFLUX, ULCERS, GALL BLADDER, IBS, ETC)

_____ GENITO-URINARY (MALE/FEMALE REPRODUCTIVE, KIDNEY, BLADDER, ETC)

_____ MUSCULOSKELETAL (BREAKS, ARTHRITIS, OSTOPOROSIS, DISCS, ETC)

_____ SKIN (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, EXZEMA, HAIR, ETC)

_____ PSYCHOLOGICAL (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC)

_____ OTHERS: _____

PLEASE DESCRIBE:

_____

_____

ADDITIONAL COMMENTS:

OFFICE USE ONLY:

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

MAY WE PUT YOUR NAME ON OUR REFERRAL BOARD? ☐ YES ☐ NO

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 SHOW 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, THE' 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 T(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 ACKNOWLEDEGEMENT 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: _____