INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise made when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, acupuncture, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy, or photolight therapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys as well as other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual risks: I have had any and all unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

_____ _____ _____ _____

Printed Name **Signature** **DOB** **Date**
(If Minor, Parent or Guardian Must Sign)

WITNESS:

_____ _____ _____

Printed Name **Signature** **Date**

Date: _____

Name:_____ *DOB*:_____

Personal and Family Health Information

Please indicate if you have any of the following conditions:

	Currently		In the Past		Family	
	Y	N	Y	N	Y	N
Heart Disease						
High Blood Pressure						
High Cholesterol or Triglycerides						
Heart Attack						
Pacemaker						
Lung Disease						
Asthma						
Allergies (environmental or industrial)						
Strokes						
Paralysis						
Peripheral Arterial Disease						
Peripheral Neuropathy						
Kidney Disease						
Cancer (type _____)						
Arthritis						
Osteoporosis						
Hepatitis- circle type A B C D						
Cirrhosis of the Liver						
Gall Bladder Trouble						
Hemochromatosis						
Pancreatitis						
Stomach Ulcers						
Hyperthyroidism						
Hypothyroidism						
Diabetes						
Chronic Back, Neck, or Spine Problems						
Multiple Sclerosis						
Parkinson's Disease						
Epilepsy						
Glaucoma						
HIV/AIDS						
Bleeding Disorder						
Leukemia						
Lymphoma						
Anemia						
Tuberculosis						
Pelvic Inflammatory Disease						
Depression/Anxiety						
History of Breast Lumps						
Other _____						
Other _____						

Date:_____

Name:_____ *DOB*:_____

Prescription Medications (please use additional sheet if necessary)

Name	Dose (mgs.)	# of Times/Day	Purpose of Medication

Prescription Medication Allergies

Drug	Type of Reaction

If you do not know of any medications you are allergic to, please check this box ☐

Supplements (Vitamins/Minerals/Herbs/Nutraceuticals, etc.)

Name	Dose (mgs.)	# of Times/Day	Purpose of Medication

Approximate Date of Last:

Physical Exam:	Chest X-Ray:
Blood Test:	Colonoscopy:
Urine Test:	EKG:
HIV/AIDS Test:	Flu Shot:
Pap Smear:	Pneumonia Shot:
Mammogram:	Tetanus Shot:
Osteoporosis Scan:	MRI, CT-Scan, or Bone Scan:

Surgeries

Description Date

_____ _____
_____ _____
_____ _____
_____ _____

Serious injuries (e.g. head injuries, falls, broken bones)

Description Date

_____ _____
_____ _____
_____ _____
_____ _____

Date:_____

Name:_____ *DOB*:_____

Today's Visit

What is the reason for your visit today?

_____

_____

What treatment have you already received for this condition, if any?
Medications Surgery Physical Therapy Chiropractic Services Acupuncture Massage
Other _____ None

What other doctors, facilities, etc., if any, have you seen for this condition? Please list names and practice locations to the best of your ability.

_____

_____

_____

If your condition involves pain, please complete the following section.

1. Is your condition getting worse? Yes No Unknown

2. Have you had anything like this before? Yes No

3. How often do you have this pain? _____

4. Please circle the best description of your pain.
Constant
On and off, lasting ____ minutes ____ hours ____ days ____ weeks at a time.

For questions 5 -7, circle all that apply.

5. Describe how it feels: Numb Aching Pins and Needles
Throbbing Cramping Stiffness Burning Stabbing Dull Sharp

6. Does it interfere with: Work Sleep Recreation Daily Routine

7. Activities that are painful to perform: Sitting Standing Walking Bending Lying Down

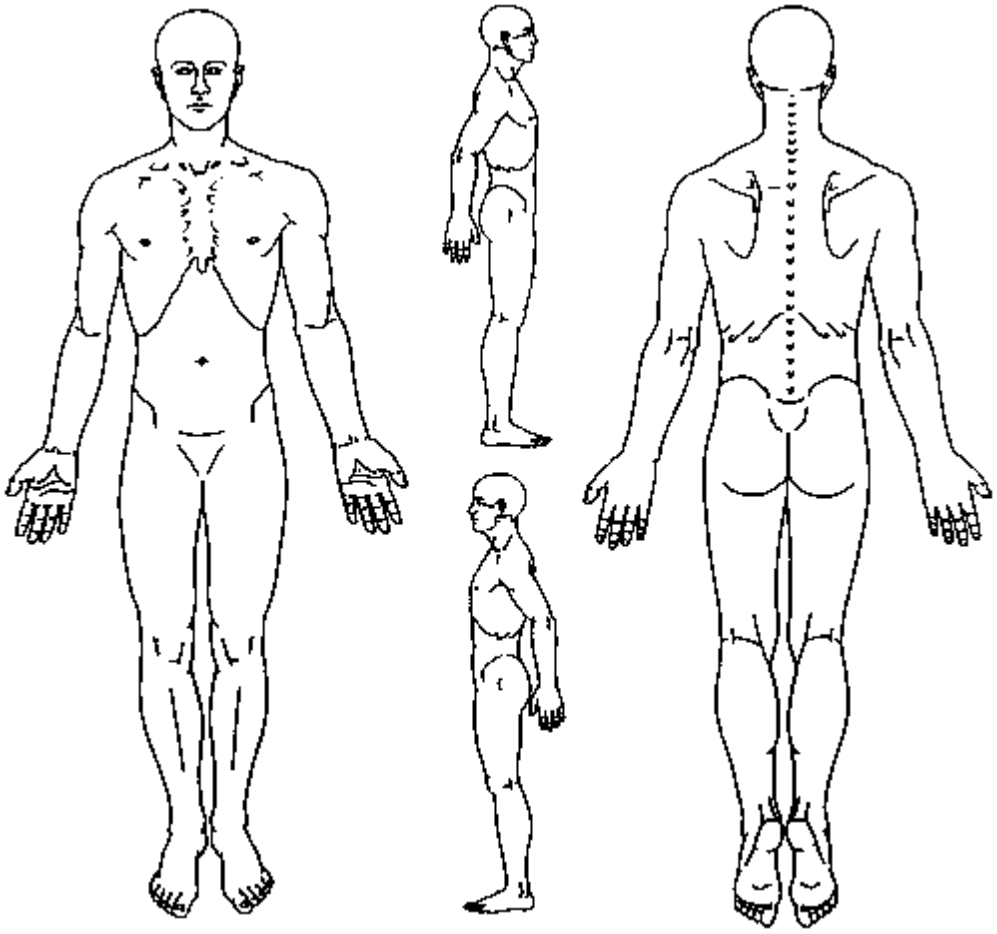
8. Please rate your pain on the scale below. 0= No Pain and 10= Severe Pain

1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Pain currently	Pain at its worst	Pain typically

Date:_____

Name:_____ *DOB*:_____

9. Please mark the area(s) of injury or discomfort as shown in the example below.
N= Numbness P= Pins and needles A= Aching B= Burning S= Stabbing



Lifestyle Questions

How many days/week do you do formal exercise (weight lifting, running, yoga, etc.)? _____
What is the main activity you do in regards to the above exercise? _____
How many times/week do you engage in aerobic sports like basketball, tennis, biking, etc? _____
Does your occupation require mostly: Sitting Standing Light Labor Heavy Labor
In your own opinion, how is your diet? Terrible Poor Average Excellent
How many 8 ounce glasses of plain water do you drink/day? _____
How many caffeinated beverages (coffee, tea, and cola) do you drink/day? _____
Do you consider yourself to be under a great deal of stress? Yes No
Do you smoke any tobacco products? Yes No If so, how often? ____
How many alcoholic beverages do you drink/week? _____
Do you use any recreational drugs? Yes No
Do you practice safe sex, if at all? Yes No
Are you currently pregnant? Yes No Due Date: _____

Please return this packet to the receptionist along with a copy of your insurance card(s) and driver's license so that we may make a copy of them.
Your doctor will be with you shortly.