Integrated Pain Solutions

Patient Health History

☐ New Patient
☐ Reactivate (1 Year)

Today's Date: _____

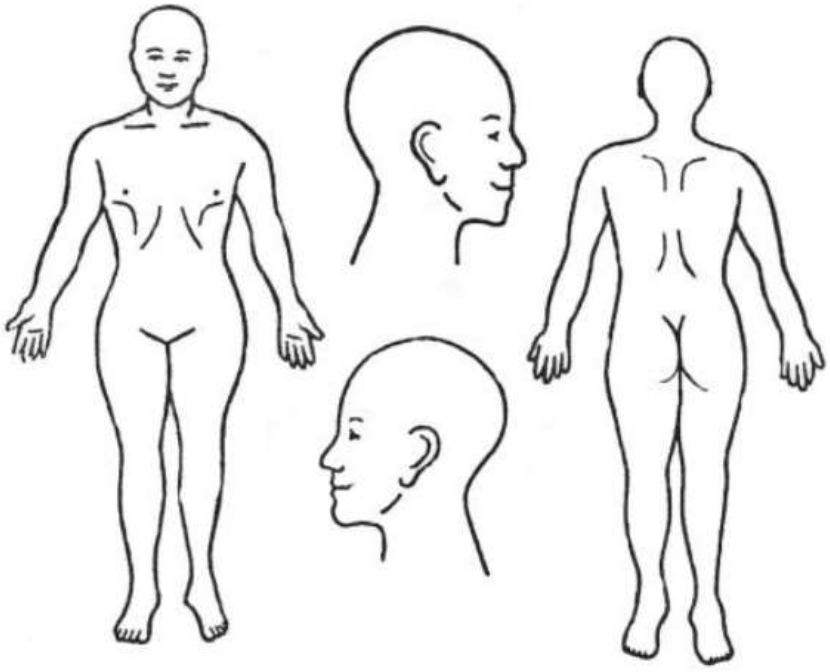
Name:	Home Phone:
Street Address:	Cell Phone:
City, State, ZIP:	Email:

Date of Birth:	Emergency Contact (Name + Relationship):	
Social Security #:	Emergency Contact Phone:	
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other: _____		Birth Sex: ☐ Male ☐ Female

How did you hear about us? ☐ TV ☐ Internet ☐ Event ☐ Friend of Dr./Staff ☐ Prior Patient _____

As accurately as possible, please mark the area with the described sensation, using the appropriate symbols.

XXX Burning Pain
(((Aching Pain
000 Pins & Needles
--- Numbness
::: Sharp Pains



Please circle your pain rating. Rate on a scale from 1 to 10 with 0 being no pain and 10 being intolerable pain.

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Intolerable Pain)

Is your pain related to a specific injury or event? ☐ Yes ☐ No

If yes, please describe the injury or event:

_____

_____

Have you had any problems with the following areas? Please check the applicable boxes.

☐ Eyes	☐ Ears, Nose, Mouth, Throat	☐ Nerves	☐ Other
☐ Skin	☐ Heart	☐ Lungs/Breathing	
☐ Intestines	☐ Internal Organs	☐ Blood	
☐ Urinary	☐ Muscles	☐ Psychological	

If you checked any of the boxes above, please describe:

_____

_____

☐ **No** ☐ **Yes** **-Have you had any major illnesses, injuries, falls, hospitalizations, auto accidents or surgeries?**

Date	Doctor Name	Condition	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

☐ **No** ☐ **Yes** **-Do you take any prescription drugs, over-the-counter drugs, vitamins, or supplements?**

Product/Drug	Reason	Frequency	Dosage	Helping?

☐ **No** ☐ **Yes** **-Do you have any allergies?**

If so, to what? _____

Family Health History

Select below medical conditions of your blood relatives (Mother, Father, Brothers, Sisters, Children)

☐ Cardiovascular (Heart) Disease Who? _____

☐ Diabetes Who? _____

☐ Arthritis Who? _____

☐ Cancer (Please list type) _____ Who? _____

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 give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Parent/Guardian/Legal Rep Signature: _____ Date: _____

D.C./C/A. Signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care. This will allow you to be fully informed when consenting to treatment prior to initiating care.

Chiropractic offices used trained personnel to assist with portions of our consultation, examination, X-rays, physical therapy applications, exercise instruction, 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 complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation. If 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 spine treatment poses a small risk. The chances of this occurring are estimated at 1 in 400,000 treatments to 1 in 5.8 million treatments (CMAJ 2001, Oct 2; 165 (7);905-6. The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). This means that the chances of a spontaneous stroke are much higher than the chance of a stroke following a chiropractic adjustment. The results of a retrospective study conducted by Haldeman S, et.al., suggested that stroke should be considered a random and unpredictable complication of any neck movement, including cervical manipulation (J. Neurol, 2002, Aug: 249(8): 1098-104).

Soreness: Chiropractic adjustments and physical therapy procedures may be accompanied by post-treatment soreness. This is a normal and acceptable response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience any soreness or discomfort.

Soft Tissue Injury: Occasionally, chiropractic treatment may aggravate a disc injury. It may also cause other minor joint, ligament, tendon, or soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment X-rays are taken for cases considered at risk. Treatment is performed carefully 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 promptly.

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are 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. If the results are not acceptable, we will refer you to another provider.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you fully understand, please print your name, sign, and date below, signifying informed consent for the treatment.

CONSENT TO TREAT A MINOR:

Having carefully read the above, I hereby give my informed consent to have the doctors and/or staff of this clinic examine, X-ray, and administer chiropractic care to my child as deemed necessary, in my presence or in my absence.

Patient's Name Printed: Today's Date:

_____ _____

Patient's Signature: Parent or Guardian Signature for Minor:

_____ _____