# PRECISION
# CHIROPRACTIC

## INFORMATION

Name:_____ DOB:_____ Date:_____

Hm Phn:(___)_____ Wk Phn:(___)_____ Cell Phn:(___)_____

Address:_____

City:_____ State:_____Zip:_____ SS#:_____

Email:_____Occupation:_____Employer:_____

Marital Status: S M D W Spouse's Name:_____

Spouse's Occupation:_____ Spouse's Employer:_____

Spouse's Work Phone:(_____)_____ Nearest Friend or Relative:_____

Insured's Name:_____ Insured's DOB:_____ Insured's SS#:_____

Insured's Address:_____

Number of Children and Ages:_____ Have You Ever Received Chiropractic Care? _____

Sleeping Posture: Side Stomach Back (circle all that apply) Date of onset/accident:_____

Description of Accident/Injury/Onset:_____

Please tell us your condition during and after the accident /onset:_____

Who may we thank for referring you to our clinic? _____

## SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Present major complaint:_____ Date symptom began:_____

Other Symptoms:

___Fever
___Headaches
___Sleeping Problems
___Cold Sweats
___Lights bothers eyes
___Nervousness
___Eye Pain
___Irritability
___Loss of weight
___Dizziness
___Nose bleeds
___Allergy
___Frequent colds
___Sinus infections
___Nasal drainage
___Stiff neck
___Tremors
___Faulty posture
___Colitis

___Chronic pain
___Hernia
___Difficult breathing
___Rapid heart beat
___Crossed eyes
___High blood pressure
___Deafness
___Earaches
___Ear noises
___Swelling of the ankle
___Sore throat
___Enlarged thyroid
___Neck pain
___Back pain
___Jaundice
___Pain over stomach
___Painful tailbone
___Constipation
___Loss of memory

__Pins & needles in arms/hands
__Inability to control urine
__Gall bladder trouble
__Prostate trouble
__Itching
__Fainting
__Wheezing
__Asthma
__Poor appetite
__Excessive hunger
__Difficult digestion
__Numbness in fingers
__Numbness in toes
__Chest pain
__Belching or gas
__Nausea
__Vomiting
__Loss of balance
__Swollen joints

___Slow heart beat
___Low blood sugar
___Low blood pressure
___Blood in urine
___Feet cold
___Hands cold
___Poor circulation
___Tonsillitis
___Fatigue
___Depression
___Liver trouble
___Colon trouble
___High blood sugar
___Frequent urination
___Face flushed
___Bedwetting
___Hardening of the arteries
___Kidney infection/stones
___Pins & needles in leg/feet

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## NEW PATIENT QUESTIONAIRE

ANSWER THESE QUESTIONS BELOW TO HELP BETTER SERVE YOU AND YOUR HEALTH GOALS.

Growth and Development

YES NO
___ ___Accidents?
___ ___Were you taught to care for your spine?
___ ___Did you play contact sports?
___ ___Childhood sicknesses?
___ ___Did you have Traumas? What? When?
_____

Current Health Habits

YES NO
___ ___ Do you smoke?
___ ___ Do you drink any alcohol?
___ ___ Have you been in accidents?
___ ___ Physical stress/Mental Stress?
___ ___ Prescriptions?
___ ___ Over-the-counter drugs?

Other health concerns: _____

Have you ever been under drug and medical care? _____ Please describe:_____

What prescriptions and over-the-counter medications are you taking? _____

How long have you been taking these medications? _____

Have you had surgery? _____ What type? _____ When?_____

What side effects have you experienced from drugs and surgery? _____

_____

Is there a family history of: Heart disease Arthritis Cancer Diabetes Other_____

Father's side: _____ _____ _____ _____ _____

Mother's side: _____ _____ _____ _____ _____

For our female patients, is there any possibility you are or may be pregnant? ___Yes ___No

Date of LMP (last period): _____

EMERGENCYCONTACT:_____PHONE:_____

Patient Signature_____Date:_____

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Length of time that you have had this pain: _____

Please rate your average daily pain from 0 (no pain) to 10 (worst possible pain): ___ /10

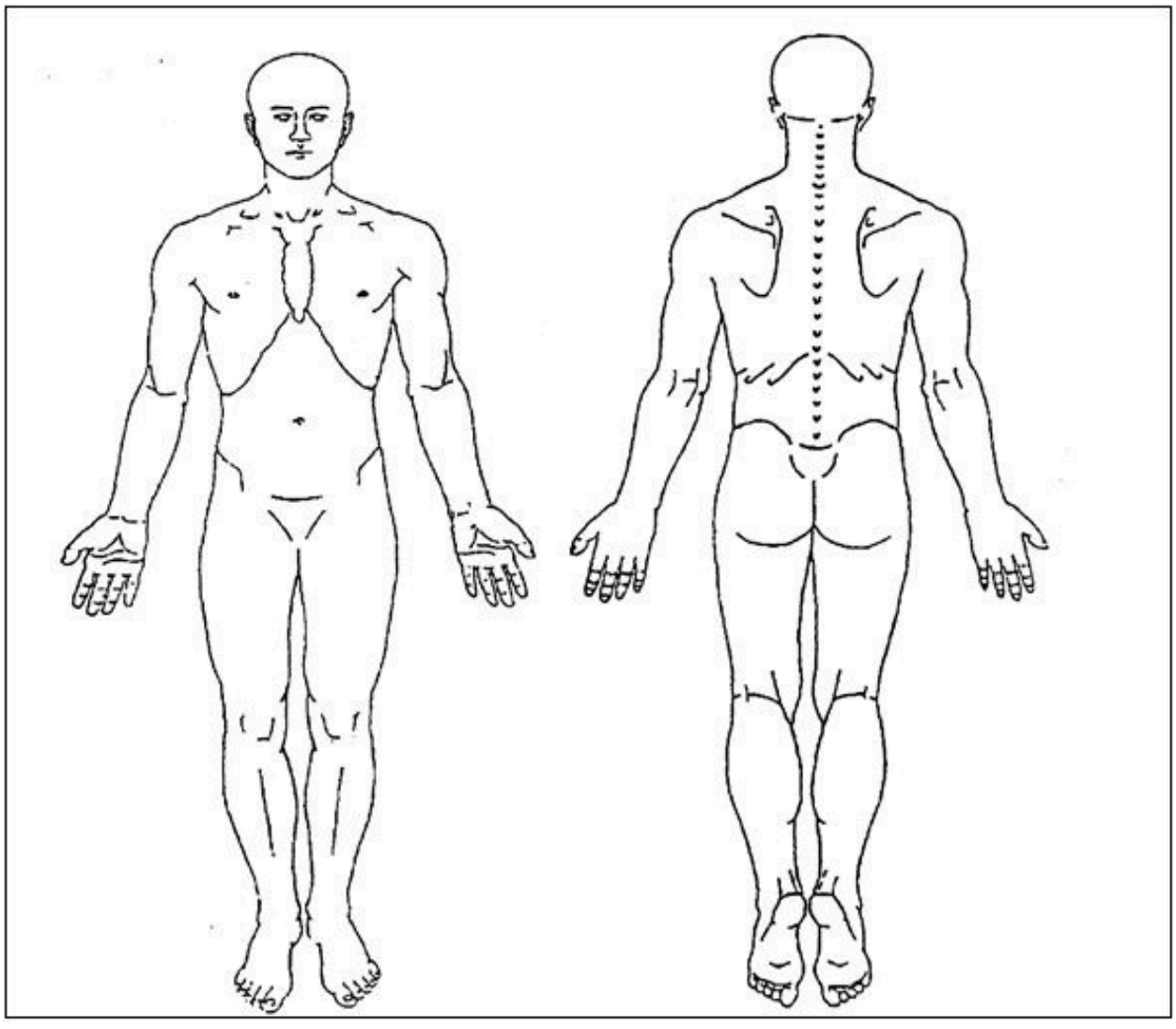
Has something or an event started your pain? Yes/ No If so what event?

_____

(C) Constant (D) Dull (B) Burning (S) Sharp (SH) Shooting (A) Aching (TH) Throbbing (T) Tingling

(N) Numbness (P&N) Pins and Needles (SW) Swelling (O) Other _____

Please mark the areas of pain on the image below and describe the type of pain on the image:



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## 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, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, 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:_____