Christensen Chiropractic S.C.

Date _____

The United States government is now requiring that all healthcare providers collect demographic and health information from their patients. This is a confidential record of your health history.
It will never be released to any other party unless you provide us with direct, written authorization.
Thank you

Name _____ Date of Birth _____ Age_____

Address _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ Cell phone: _____

Cell Phone Carrier (if you would like appointment reminders via text message) _____

E-mail address: _____

What is your preferred method of contact?

Call to Home Call to Cell Text message to cell Email **(Please circle)**

Ethnicity:

Hispanic / Latino or Not Hispanic / Latino **(Please circle)**

Race: (Please circle)

White Black/African American Asian American Indian Native Hawaiian/Pacific Islander Two or more

Preferred Language: (Please circle)

English Spanish French German Italian Mandarin Cantonese Tagalog Japanese Other_____

Is your visit today caused by a work injury? _____ Date _____ Reported to your employer?_____

Is your visit today caused by a personal injury? _____ Date _____ Have you retained an attorney?_____

Who may we thank for referring you? _____

PATIENT CONDITION

Describe your current physical complaint(s) or symptoms. _____
_____
_____

Have you ever had this problem before? _____ When? _____ When did this problem start? _____

PRESCRIBED MEDICINES

Check here if not taking any medications**:** ☐

Medication (e.g Lipitor)	**# of MD refills issued**	**Quantity of Pills**	**Strength** (e.g.10 mg)	**Dose Form** (e.g. capsule)	**MD's instructions** (e.g. 1 per day)

Are you allergic to any medicines: Please list each drug below:
Check here if you do not have any medical allergies: ☐

Name of Drug (e.g. Penicillin)	**Symptoms**

List any surgeries you have had _____

Please describe any previous treatment or tests you've had for this problem:

Treatment	Name of Doctor/Facility	Results
❑ Chiropractor		
❑ Medial Doctor		
Tests		
❑ X-rays		
❑ MRI		
❑ CT scan		

Please Check all that apply:

- ❑ Headaches
- ❑ Neck Pain
- ❑ Dizziness
- ❑ Sinus Trouble/Allergies
- ❑ Elbow/wrist pain
- ❑ Pain between the shoulders
- ❑ Shoulder pain
- ❑ Pain/numbness in arm or hand
- ❑ Difficulty breathing
- ❑ Foot/ankle/knee pain
- ❑ Lower back pain
- ❑ Pain/numbness in legs and feet
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Constipation

Women Only: Are you pregnant? _____

Have you been diagnosed with either of the following:

Diabetes Asthma High Blood Pressure **(Please circle)**

Smoking Status:

Smokes every day Smokes some days Former Smoker Never Smoked **(Please circle)**

If you smoke, how many cigarettes do you smoke per day? _____

Please describe your immediate family members:

Family Member	If Living		If Deceased	
	Age	Health	Age at death	Cause
❑ Mother				
❑ Father				
❑ Brother/Sister				
❑ Brother/Sister				
❑ Brother/Sister				

- I hereby consent to treatment by the doctors at Christensen Chiropractic. If applicable, I hereby consent to have treatment provided for my minor child.
- I understand that any applicable insurance forms will be submitted by this clinic with full documentation of services performed, and that I am ultimately responsible for payment of services rendered
- I authorize all benefits provided by my insurance plan(s) to be paid directly to Christensen Chiropractic on my behalf.
- I understand a 1% per month (12% per year) late payment fee will be assessed on any unpaid balance after 30 days from date of statement**.**

_____ _____

Signature Date

_____ _____

Signature of parent or guardian in under 18 Date

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Pain Evaluation

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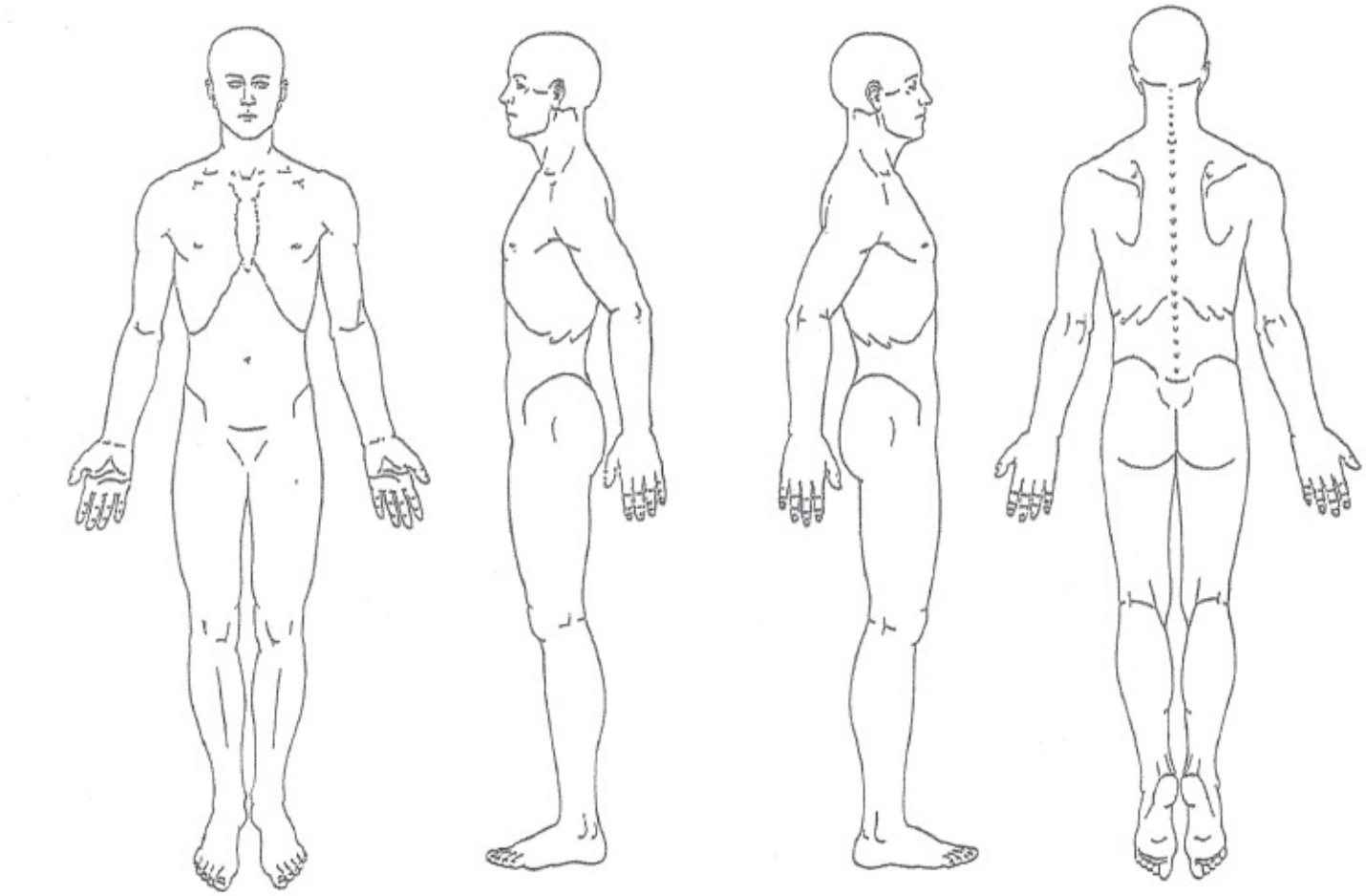
Name: _____ Date: _____

1. Shade in the areas on the diagrams which are painful or uncomfortable for you.

2. Grade the areas of pain or discomfort on a scale from 1 to 10.
   (1 being "just noticeable" pain and 10 being the worst pain imaginable)

3. Make an "x" to represent your overall level of pain or discomfort on the line at the bottom of the page.



Overall Pain or Discomfort Scale

(No Pain) _____ (Worst Pain Imaginable)

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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" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. 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 other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often than complications from taking a single aspirin tablet.. There has not been a single reported injury in our clinic since its inception in 2001.

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

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *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.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks 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 future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation 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 hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date