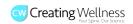
CHIROPRACTIC INTAKE & HISTORY



Patient Name					Employer / School						
LAST NAME					Occupation	Occupation					
Address	FIRST NAME		MIDDLE	INITIAL							
	State			·	Spouse's Name						
						Spouse's Employer					
					·	Spouse's Occupation IN CASE OF EMERGENCY, CONTACT Name					
Cell Phone											
mail											
Sex □ M	,					hip					
☐ Married	☐ Widowed ☐ Single ☐ Minor				Contact N	lumber					
■ Separated	☐ Divorce	ed 🗖	Partnered		Who may	we thank for referri	ng you?				
	N WE HE										
What brings yo	ou iii today? _										
f you are alrea	idy experiencin	g a sympto	m, what is it?								
	How intense a			SYMPTOMS	3	3 4 6	6 7		INTENSE YMPTOMS		
	eel like? (checl	c where an	oropriate)	, ,		\bigwedge_{Λ}					
What does it fo	eel like? (checl	-	oropriate)					\			
What does it fo	_	Sharp	oropriate)	, ,							
What does it for a Numbness Tingling		Sharp Shooting	oropriate)								
What does it for Numbness Tingling Stiffness		Sharp Shooting Burning	oropriate)								
What does it for a Numbness Tingling Stiffness Dull		Sharp Shooting Burning Throbbing	oropriate)								
What does it for Numbness Tingling Stiffness Dull Aching		Sharp Shooting Burning Throbbing Stabbing	propriate)								
What does it for a Numbness Tingling Stiffness Dull Aching Cramping		Sharp Shooting Burning Throbbing	oropriate)								
What does it for a Numbness Tingling Stiffness Dull Aching Cramping		Sharp Shooting Burning Throbbing Stabbing	oropriate)								
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		ILL	NESS	-WELL	.NES	s co	NTINU	JUM				
				CO	MFO	RT						
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MATURE DEATH						VELLNESS)				WELLNESS		
0	1	2	3	4	5	6	7	8	9	1	0	
				24								
DISEASE Multiple medications										OPTIMAL HEALTH 100% function		
Poor quality of life Potential becomes limited	Poor quality of life Drug therapy Nutrition i				ion incons	nptoms Regular exercise nconsistent Good nutrition sporadic Wellness education high priority Minimal nerve interference			Conti	nuous de tive parti	velopment	
Body has limited function										'ellness li		
							'		·			
n the arrow diagram abo												
A. What number do you	•	,		,								
B. In what direction is yo	our health	currently	headed? _									
/hat are your health goals												
IMMEDIATE												
SHORT TERM												
LONG TERM _												
CHILDREN & PI												
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How many children do you	REGNAL Have? _	ANCY	7		-	Number of	of past preg	gnancies?				
How many children do you	REGNAL Have? _	ANCY	7		-	Number of		gnancies?				
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CONSENT

I CONSENT TO A PROFESSIONAL AND COMPLETE CHIROPRACTIC EXAMINATION AND TO ANY RADIOGRAPHIC EXAMINATION THAT THE DOCTOR DEEMS NECESSARY. I UNDERSTAND THAT ANY FEE FOR SERVICE RENDERED IS DUE AT THE TIME OF SERVICE AND CANNOT BE DEFERRED TO A LATER DATE.

CHIROPRACTIC CARE IS RECOGNISED AS BEING AN EFFECTIVE AND SAFE METHOD OF CARE FOR MANY CONDITIONS. HOWEVER, YOU MUST RECOGNISE THAT THERE ARE RISKS ASSOCIATED WITH ALL HEALTH CARE PROCEDURES, INCLUDING ASSESSMENT AND TREATMENT, WHICH YOU SHOULD BE INFORMED ABOUT. PLEASE READ THE FOLLOWING CAREFULLY:

- 1. I ACKNOWLEDGE THAT I HAVE DISCUSSED WITH THE CHIROPRACTOR THE RARE RISKS ASSOCIATED WITH MY PROPOSED CARE WHICH INCLUDE BUT ARE NOT LIMITED TO; MUSCLE AND JOINT SORENESS OR STRAINS, NAUSEA AND DIZZINESS, FRACTURES, DISC INJURIES INCLUDING DISC ENCROACHMENTS/RUPTURES, CAUSING NERVE IRRITATION AND REFERRED SYMPTOMS, STROKES (OR LIKE EPISODES) AND AN EXACERBATION AND/OR AGGRAVATION OF MY UNDERLYING CONDITION. SUCH RISKS MAY RESULT IN OUTCOMES SUCH AS REFERRAL, FURTHER TESTS, SURGERY, INCAPACITY AND THE LIKE.
- 2. I ALSO ACKNOWLEDGE THE FOLLOWING ADDITIONAL POTENTIAL RISKS INSOFAR AS MY PROPOSED CARE IS CONCERNED HAVE BEEN EXPLAINED TO ME.
- 3. I HAVE HAD THE OPPORTUNITY TO DISCUSS THE PROPOSED CARE WITH THE CHIROPRACTOR. I ALSO ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE NATURE, EXTENT AND PURPOSE OF THE PROPOSED CHIROPRACTIC CARE AND THAT I HAVE BEEN GIVEN SUFFICIENT TIME TO MAKE A DECISION GIVING CONSENT FOR THE CARE TO PROCEED.
- 4. I ACKNOWLEDGE THAT I AM AWARE OF AND UNDERSTAND THE POTENTIAL RISKS. I APPRECIATE THAT RESULTS ARE NOT GUARANTEED. I DO NOT EXPECT THE PRACTITIONER TO BE ABLE TO ANTICIPATE ALL POTENTIAL RISKS AND COMPLICATIONS ASSOCIATED WITH THE PROPOSED CARE.
- 5. I HEREBY ACKNOWLEDGE MY CONSENT TO THE PERFORMANCE OF THE PROPOSED CHIROPRACTIC CARE. I UNDERSTAND THAT I CAN WITHDRAW CONSENT AT ANY TIME.
- 6. IN VERY RARE CIRCUMSTANCES, SOME TREATMENTS OF THE NECK MAY DAMAGE A BLOOD VESSEL AND LEAD TO STROKE OR RELATED SYMPTOMS (CURRENT STATISTICS BETWEEN 1 IN 2 MILLION TO 1 IN 5.85 MILLION -HALDEMAN, ET AL. SPINE VOL 24-8 1999). OTHER POSSIBLE RISKS INCLUDE STRAIN/INJURY TO A LIGAMENT OR A DISC IN THE NECK (CURRENT STATISTICS E.G. LESS THAN 1 IN 139,000) AND THE LOW BACK (CURRENT STATISTICS E.G. 1 IN 62,000 DVORAK STUDY IN PRINCIPLES & PRACTICE OF CHIROPRACTIC, HALDEMAN 2ND ED.). FOR SOME PATIENTS ESPECIALLY WITH BONE WEAKENING DISEASES, A FRACTURE OF A BONE ALTHOUGH RARE IS POSSIBLE."

PRINT YOUR NAME	DATE	SIGNATURE