ChiroFlo

New Patient Intake Form

PATIENT INFORMATION

Name [Print]: _______________________________________ Date: ______________

Phone: __________________ Email: __________________________ Date of Birth: _________

Address: ____

Sex [circle]: Male Female Occupation: ____

Emergency Contact: ____
Name Phone

How did you hear about our office: ____

CHIEF COMPLAINT

Reason for visit:____ Date of onset:________________

What motions/postures are aggravating: ____

What brings relief: ____

The pain feels [circle]: sharp dull aching stabbing

Does the pain radiate to any other area of body: Y/N Where: _____________________________________

Pain rating [circle]: 0 1 2 3 4 5 6 7 8 9 10
No Pain **Extreme Pain**

The pain is [circle]: Constant Frequent Occasional

Where is the pain located [circle]: Left side Right side Both sides

What do you hope to gain from treatment: ____

____

HEALTH HISTORY

Who is your primary care physician? ____

Please list any past hospitalizations/surgeries: ______________________________________

____

Please list your current medications/supplements: ___________________________________

____

Please list any allergies: ____

Please check if you are currently experiencing any of the following conditions:

- Neck Pain/ Stiffness
- Back Pain/ Stiffness
- Arm/Hand Pain
- Leg/Knee Pain
- Headaches
- Dizziness
- Pins/Needles in Arms/Legs
- Night Pain
- Sudden Weight Loss
- Jaw Problems
- Bathroom Changes
- Cold Feet
- Chest Pain

Please Check if you have you ever been diagnosed with any of the following conditions:

- Aids/HIV
- Arthritis
- Cancer
- Diabetes
- Fractures
- Gout
- Herniated Disc
- Migraines
- Pinched Nerve
- Parkinson's Disease
- Polio
- Osteomyelitis
- Osteoporosis
- Rheumatoid Arthritis
- Stroke
- Ankylosing Spondylitis
- Hyper-mobile joints
- Benign bone tumors
- Cauda equine syndrome
- Thoracic aortic dissection
- Abdominal aortic aneurysm [AAA]
- Radiculopathy
- Joint hyper mobility at C1/C2 [atlantoaxial instability]
- Unstable os odontoideum [Dens]
- Pacemaker
- Other: __________

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature [X] ____ **Date:** _________________

Informed Consent

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask any questions before signing if you have any uncertainty.

The nature of the chiropractic adjustment
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" much like when you crack your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustments
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care. If you have a condition that would otherwise not come to the Doctor's attention it is your [patient] responsibility to inform the Doctor.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medial research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other treatment options
Some other options for treating your condition may include:
- Self-administered, OTC analgesics and rest
- Medical care and prescription drugs [pain-killers, NSAIDS, muscle relaxants]
- Hospitalization
- Surgery

If you choose to use any of the above noted treatment options you should be aware that there are risks and benefits of such options and you should discuss these with your primary care physician before beginning any treatment.

The risks and dangers of remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT

[MINOR] I hereby request and authorize Dr. Gibbs to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter ____________________________. This authorization also extends to all other Doctors and office staff members and is intended to include radiographic examination at the Doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

[ ] Yes **[ ] No**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: ____ **Date:** ______________

Patient Signature: ____

Guardian/Parent [for minors] Signature: ____

Doctor's Name: ____ **Date**: ________________

Doctor Signature: ____