

Patient Information			
Date: ____/____/____			
Social Sec. # _____			
Patient Name _____			
	Last Name	First Name	Middle Initial
Address _____			
City _____			
State _____		Zip _____	
E-mail _____			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Age _____	
Birthdate ____/____/____			
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered			
Occupation _____			
Patient Employer/School _____			
Employer/School Address _____			
City _____			
State _____		Zip _____	
Employer/School Phone _____			
How did you hear about us? _____			
Spouse's Name _____			
Birthdate _____			
SS# _____			
Spouses Employer _____			

Staff Use Only
<ul style="list-style-type: none"> • Patient Chief Complaint Summary: _____ _____ • SP Symptom Survey Form: _____ _____ • Wellness Wheel Total Score: _____ Lowest: _____ • Toxicity Form - Section I: _____ Section II: _____ Total: _____ • Acidity Form - Section I: _____ Section II: _____ Total: _____ • Posture Exam Notes: _____ _____ • Thermography Notes: _____ _____ • X-Rays Taken: <input type="checkbox"/> C-SP <input type="checkbox"/> T-Sp <input type="checkbox"/> L-Sp <input type="checkbox"/> ___ Shoulder <input type="checkbox"/> ___ Elbow <input type="checkbox"/> ___ Knee <input type="checkbox"/> ___ Foot • Diagnosis Codes: _____ _____

Phone Numbers
Home Phone (____) _____
Cell Phone (____) _____
Best time and place to reach you _____
In Case of Emergency Contact _____
Name _____
Relationship _____
Home Phone _____
Work Phone _____

Accident Information
Is condition due to an accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Accident ____/____/____
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other
Who have you made a report of your accident?
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work Comp. <input type="checkbox"/> Attorney <input type="checkbox"/> Other
Attorney Name (if applicable) _____
Claim Adjuster (if applicable) _____
Case Manager (if applicable) _____
Case # _____

Informed Consent
<ul style="list-style-type: none"> • We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient. • Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. • I authorize the staff of Lake Cities Chiropractic Center to perform any and all necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. • I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.
Signature _____ Date ____/____/____ <input type="checkbox"/> Adult <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Representative

Consent for X-Ray Examination
I _____ do hereby give my permission to Lake Cities Chiropractic Center and its representatives to take X-RAYS as deemed appropriate by the examining doctor. I also hereby declare that to my knowledge, I am not pregnant.
Signature _____ Date _____

Health History

What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractor Other: _____

Name and address of other doctor(s) who have treated you for your condition? _____

Date of your last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Bone Density _____
MRI, CT-Scan, Bone Scan _____ Urine Test _____ Posture Exam: _____

Place a mark on Y or N to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Miscarriage	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Alcoholism	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Suicide Attempt	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Fractures	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mumps	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N	Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Appendicitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gonorrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteopenia	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Parkinson's	<input type="checkbox"/> Y <input type="checkbox"/> N	Typhoid	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Pinched Nerve	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Breast Lump	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Infections	<input type="checkbox"/> Y <input type="checkbox"/> N
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Herniated Disc	<input type="checkbox"/> Y <input type="checkbox"/> N	Polio	<input type="checkbox"/> Y <input type="checkbox"/> N	Whooping Cough	<input type="checkbox"/> Y <input type="checkbox"/> N
Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Other ▶	
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthesis	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N		
Drug Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N		
Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N	Measles	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N		
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N		

Exercise	Work Activity	Habits	Please List Any Significant Injuries	Date
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	<input type="checkbox"/> Falls	
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Broken Bones	
<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate Labor	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Dislocations	
<input type="checkbox"/> Training	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress	<input type="checkbox"/> Sprain/Strains	

Medications	Allergies	Vitamins/Herbs/Minerals	Please list Any Surgeries	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

- What would you like to achieve from seeking care at our office? (eg.. better health, better range of motion, get out of pain...) _____
- What do you feel is or has been hindered by the condition(s) you are seeking help for? (eg.. golf game, driving, sitting, play with kids) _____
- What, if any are your previous experiences with chiropractic care? (eg.. good, bad, certain adjustment technique) _____
- Would you be interested in utilizing Clinical Aromatherapy/Essential Oil Therapy in conjunction with your treatment at our office?
 Yes No Comments: _____
- Do we have permission to communicate with you through e-mail? Typically we may use e-mail for the following: Sending and receiving forms, exercise plans, goal worksheets, information updates, monthly newsletters, clinic specials on products ect... This authorization is effective through 01-01-2015 unless written revocation to this office is received. _____ Initial Please.
 Yes No E-mail you would like us to use: _____

Chief Complaint: _____

Where did the problem begin? Home Work Play Travel

Date of Onset: _____

Mode of Onset: Sudden Gradual Worsening Chronic

Location: Neck Mid-Back Low Back Pelvis Other: _____

Consulted any other Dr.'s for this condition? Yes No

Name: _____

Address: _____

Still under care? Yes No | PCP Ortho Neuro

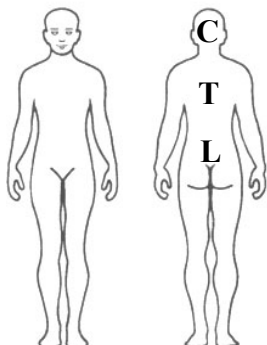
Prescription(s): _____

Remarks: _____

Was surgery recommended? Yes No : _____

Result of Treatment? Good Condition worse No Change

FRONT



BACK

Pain: C 1 2 3 4 5 6 7 8 9 10 T 1 2 3 4 5 6 7 8 9 10 L 1 2 3 4 5 6 7 8 9 10

Quality: Dull Sharp Stabbing Ache Tingle Numb
 Burn Tight Locked Soreness Annoying

Frequency: Constant Intermittent Intensity Fluctuates

Hindered: ADL Sports Kids Work

Radiate? R L Shoulder Arm Hand Leg Foot

Has it gotten progressively? Worse Better No Change

Aggravating Factors? Walking Sitting Standing Sleep

Worse w/ Activity? Yes No: _____

Reliving Factors? _____ Pt. Denies

Do any positions relieve the pain? Yes No No Change

Sitting Walking Lying: Up Down Side _____

Position you sleep in? Face Up Face Down Side _____

Is the Condition: Better Worse N/C in the AM PM

Has it affected any other systems? Yes Pt. Denies

Urinary Bowel Cardiac Respiratory Vision

Do you get Headaches? Yes No **Frequency:** ___ da/wk/mo

Is it worse if you cough or sneeze? Yes No **Loc:** _____

Is the patient house confined? Yes No **Duration:** _____

Have you missed work? Yes No **Amount:** _____

Date patient returned to normal work? ___/___/___ N/A

Have you ever had this condition before? Yes No

When: _____ # of prev. episodes? _____

Duration: _____

Treatment: Chiro. MD DO PT Other: _____

Results: Good Condition worse No Change

Have administered any home remedies? Yes No

OTC Ice Heat Massage Analgesic Creams

What: _____

Result: Did it help? Yes No _____

Diagnosis 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you had previous chiropractic care? Yes No

Location: _____

When: _____ **Last Adjustment** ___/___/___

Why: _____

X-rays on file: Yes No **Loc:** C T L P E

Result of Treatment: Good Condition worse No Change

Do you have any secondary complaints? _____

Have you Previously worn custom orthotics? Yes No

Have you Previously undergone rehabilitation? Yes No

Have you ever undergone spinal decompression? Yes No

Have you ever had your spine scanned for neurological disturbances? Yes No

Do you normally take vitamins or supplements? Yes No

Are you currently dieting or watching your weight? Yes No

Do you drink adequate water on a daily basis? Yes No

Do you currently have a gym membership? Yes No

Do you eat out more frequently than at home? Yes No

Do you have meals on a regular basis? Yes No

Would you generally say that you are happy? Yes No

Do you drive long distances in traffic frequently? Yes No

Are you conscious about your posture? Yes No

Our patients choose our office because they want a natural approach to better health. On your first visit you'll meet the doctor to discuss your current health situation and to see if you're a good candidate for chiropractic care. If we think we can help, we'll conduct a thorough examination. This helps us identify the likely cause(s) of your problem. We'll tell you what we found, what we can do to help, how long it may take and how much it will cost. Our office enjoys high levels of patient satisfaction because we explain everything in advance. Find out for yourself!

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Lake Cities Chiropractic Center, P.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient **Date**

Signature of Patient Representative **Date**

Relationship of Patient Representative to Patient

Office Representative **Date**

Others we may release your PHI to

Wellness Questionnaire

ON A SCALE OF 0 (POOR) TO 10 (EXCELLENT) MARK YOUR CURRENT HEALTH LEVELS IN THESE 7 ESSENTIAL AREAS.

1. Mental Health

- a. Are you open to new ideas? Do you seek out new ideas and experiences to learn new skills what is the quality of the information and information that you allow into your mind?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

2. Physical Health

- a. What is your physical condition? Are you receiving good nutrition, drinking plenty of water, getting regular exercise, and enjoying the proper weight for your height?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

3. Financial Health

- a. Are you living within your means? Is your debt within manageable limits? Do you make charitable contributions and save for the future? Are you properly insured?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

4. Family Health

- a. Are you in a loving relationship with shared values? Do you give your family time and attention? Do you have a close connection with children, parents, and relatives?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

5. Social Health

- a. How well do interact with others? Are you able to maintain long-term friendships? Are you comfortable in new social situations and the company of others.
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. Career Health

- a. Do you like what you do for a living? Does your career reflect and advance your deepest values? Is your work meaningful and suited to your skills and interest?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

7. Spiritual Health

- a. How connected do you feel to the higher power in your life? Do you enjoy a sense of purpose and peace? Do you regularly study, meditate, pray or worship?
- b. Rate Yourself accordingly: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Your health affects everything you do and everyone you know. We use this confidential worksheet to record a "snapshot" of your estimated overall health so we can track your progress.

Toxicity Questionnaire

SECTION I: SYMPTOMS - Rate each of the following based upon your health profile for the past 90 (Ninety) days.

Use This Key – Circle the corresponding number below for Section I, groups 1-15

0	Rarely or never experience the symptom	3	Frequently experience the symptom, the effect is not severe.
1	Occasionally experience the symptom, the effect is not severe.	4	Frequently experience the symptom, the effect IS severe.
2	Occasionally experience the symptom, the effect IS severe.		

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloating feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4
Total:	_____				

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches, ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears, hearing loss	0	1	2	3	4
Total:	_____				

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Apathy / Lethargy	0	1	2	3	4
Total:	_____				

4. ENERGY / ACTIVITY

a. Fatigue / Sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4
Total:	_____				

5. EYES

a. Watery, itchy eyes	0	1	2	3	4
b. Swollen, reddened, sticky lids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred / tunnel vision	0	1	2	3	4
Total:	_____				

6. HEAD

a. Headache	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4
Total:	_____				

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma, Bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4
Total:	_____				

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4
Total:	_____				

9. MOUTH / THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging, need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums or lips.	0	1	2	3	4
d. Canker sores	0	1	2	3	4
Total:	_____				

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4
Total:	_____				

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4
Total:	_____				

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid Heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4
Total:	_____				

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness, limited movement	0	1	2	3	4
e. Pain, aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tired	0	1	2	3	4
Total:	_____				

14. WEIGHT

a. Binge eating/drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4
Total:	_____				

15. OTHER

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4
Total:	_____				

SECTION I TOTAL: _____

SECTION II RISK OF EXPOSURE: Answer the following situations based upon your environmental profile for the past 120 days.

0 Never **1** Rarely **2** Monthly **3** Weekly **4** Daily

16. Circle the corresponding number for questions 16a-16f below

a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven/drain cleaners, furniture polish, floor wax etc.)	0	1	2	3	4
b. How often are pesticides used in your home?	0	1	2	3	4
c. How often do you have your home treated for insects?	0	1	2	3	4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, varnish in your home or office?	0	1	2	3	4
e. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?	0	1	2	3	4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4

0 No **1** Mild Change **2** Moderate Change **3** Drastic Change

17. Circle the corresponding number for questions 17a-1b below

a. Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
b. Have you noticed any negative change in your health since you started your latest job?	0	1	2	3

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	NO	YES
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total Score > 40 or greater than 6 points per section, Clinical Purification is suggested. I II III **SECTION II TOTAL:** _____

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”, such as the noise 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 dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. 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 minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

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

- *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.
- *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.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *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 explanation above 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

WITNESS:

Printed Name

Signature

Date