Kaliko Chiropractic

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and / or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, dislocations, strokes and sprains. I do not need or expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intended this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Print Patient's Name or Name of Patient Representative	Relationship	Date
Signature Patient's Name or Name of Patient Representative	Relationship	Date

CONSENT TO TREATMENT OF MINOR

I (we) being the parents (s) of _____, a minor, the age of _____ years, do hereby consent, authorize and request Kaliko Chiropractic, Dr. Michael Kaliko, and whomever he may designate as his assistant to administer treatment as he / she so deems necessary on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications, which may result from treatment.

Signature of Parent or Guardian	*Signature* of Witness	Date

SIGNATURE ON FILE

I authorize use of this information on all my insurance submissions.
I authorize release of information to all my insurance companies.
I understand that I am responsible for all my bills.
I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.
I authorize that I am responsible for payment of an office visit on all missed appointments lacking a 24 – hour cancel notice.

Print Name	*Signature*	Date

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me will be immediately due and payable. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I, the undersigned, affirm and declare that I have been advised by the Doctor's office that the bringing of a fraudulent claim is a crime punishable by imprisonment and / or fine, and that the Doctor's office will not treat and / or be part of such fraudulent claims. I hereby authorize the Doctor to examine and treat any condition as he / she deems appropriate through the use of Chiropractic Health Care. I give authority for all of these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-ray negatives will remain the property of this office. I also agree that I am responsible for all bills incurred at this office.

Signature of Patient, Parent or Guardian authorizing care	Date

CURRENT HEALTH CONDITION

Current Condition_____
Other Doctor's Seen For This Condition Yes No; Who?_____
Type of Treatment: _____
Results: _____
Date of Injury:_____ Time of Injury:_____ Has This Condition Occurred Before? Yes No
Is This Condition Job Related? Yes No Did You Make A Report of The Accident To Your Employer: Yes No
Is Condition: Auto Accident Fall Gym Home Injury Sports
Medications You Now Take: Pain Killers Muscle Relaxers Blood Pressure Insulin
Others _____
Do You Wear A Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?
_____

1. Check only *ONE* body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations:_____
7. Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

2. Types of pain

☐Dull	☐Sharp	☐Aching	☐Cutting
☐Throbbing	☐Burning	☐Numbing	☐Tingling
☐Spasm	☐Stinging	☐Shooting	☐Pounding

Other types of pain:
_____
☐Cramping _____
☐Constricting

3. Pain Frequency
☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects daily activities)
☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of Radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

1. Check only *ONE* body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations:_____
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☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of Radiation:_____

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☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

Name:_____ **Date:**_____

PAST HEALTH HISTORY

PLEASE CHECK OR DESCRIBE:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other: _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment, However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Pneumonia
- Rheumatic Fever
- Asthma
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Thyroid
- Influenza
- Pleurisy
- Arthritis
- Epilepsy
- Mental Disorders
- Eczema

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWINGYOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Difficult Chewing/Clicking Jaw
- Neck Pain
- Pain Between Shoulders
- Arm Pain
- Lower Back Pain
- Sciatica
- Hip/knee
- Ankle
- Foot
- Walking Problems
- Joint Pain/Stiffness
- Poor Posture
- Spinal Curvature

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Kidney Stones/Infection

FEMALES ONLY:

When was your last period? _____

Are you pregnant? Yes No Not Sure

NERVOUS SYSTEM

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Chills
- Fever
- Sweats
- Headaches
- _____

MALE / FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Lumps
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FAMILY HISTORY

The following members have a similar or same problem as I do:

- Mother
- Father
- Sister
- Brother
- Spouse
- Child

NAME _____ **DATE** _____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below.
Use the following 1 to 5 scale.

WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty:

1 = "I can do it without any difficulty"
2 = "I can do it without much difficulty, despite some pain"
3 = "I manage to do it by myself, despite marked pain"
4 = "I manage to do it, despite the pain, but only if I have help"
5 = "I cannot do it all, because of the pain"

Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing____	Drying hair____	Brushing teeth____	Putting on shoes____	Preparing meals____	Taking out trash____
Showering____	Combing hair____	Making bed____	Tying shoes____	Eating____	Doing laundry____
Washing hair____	Washing face____	Putting on shirt____	Putting on pants____	Cleaning dishes____	Going to toilet____

Difficulties with Physical Activities

Standing____	Walking____	Kneeling ____	Bending back ____	Twisting left____	Leaning back____
Sitting____	Stooping____	Reaching____	Bending left____	Twisting right____	Leaning left____
Reclining____	Squatting____	Bending forward____	Bending right____	Leaning forward____	Leaning right____

Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____	Lifting weights off floor____	Pushing things while seated____	Exercising upper body____
Carrying large objects____	Lifting weights off table____	Pushing things while standing____	Exercising lower body____
Carrying brief case____	Climbing stairs____	Pulling things while seated____	Exercising arms____
Carrying large purse____	Climbing inclines____	Pulling things while standing____	Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____	Jogging____	Swimming____	Ice Skating____	Competitive Sports____	Dating____
Golfing____	Dancing____	Skiing____	Roller Skating____	Hobbies____	Dining out____

Difficulties with Travelling

Driving a motor vehicle____	Riding as a passenger in a motor vehicle____	Riding as a passenger on a train____
Driving for long periods of time____	Riding as a passenger on an airplane____	Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below :

1 = "This area is not affected by my condition"
2 = "This area is slightly affected by my condition"
3 = "My condition moderately restricts my ability in this area"
4 = " My condition seriously limits my ability in this area"
5 = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

NAME_____ **DATE**_____