Intake Form

Chiropractic

Patient Information

Patient Name _____ Date of Birth _____ Age _____

Cell Phone Number _____ Email _____ *Male* *Female*
(will be used to sign in)

Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone Number _____

How did you hear about our office? _____

Are you Medicare eligible? *Yes* *No*

Acceptance of Care

WHAT WE OFFER

At Blackwell Chiropractic, we offer chiropractic adjustments at the discretion of the licensed chiropractors, for the purpose of correcting spinal subluxations, which may result in increased range of motion, reduced joint fixation, improved function of the spine, and lessened pain related to the spinal subluxations.

In order to administer chiropractic adjustments in a safe and effective manner, our licensed chiropractors will perform a comprehensive patient history and physical exam. This will include a spinal exam, which will assess the function and integrity of the spine, and will determine if any subluxations are present.

When indicated, our licensed chiropractors may feel it is necessary to perform additional tests such as diagnostic x-rays, MRI, or other physical procedures before beginning care. If additional testing is needed, our licensed chiropractors will make referrals to the appropriate providers. This may mean you will not be seen on the date of your initial visit, or will not been seen at all, if it has been determined unsafe.

WHAT WE DO NOT OFFER

We do not offer to diagnose or treat any condition other than subluxations, or joint dysfunction, of the spine and extremities. We do not have diagnostic capabilities other than the training and experience of the licensed chiropractors. We do not offer any treatment other than chiropractic adjustments to the spine and extremities. If, in the professional opinion of the licensed chiropractors, the patient needs more testing, diagnosis, or treatment, the patient will be referred to another appropriate provider.

I, _____, have read and fully understand the above explanation of care. I accept and consent to the chiropractic care described above.

Patient or Guardian Signature _____ Date _____

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Lifestyle

Exercise	Activity	Habits
None	*Sitting* Hours per day _____	*Smoking* Cigarettes per day _____
Light	*Standing* Hours per day _____	*Alcohol* Drinks per week _____
Moderate	*Manual Labor* Hours per day _____	*Soda* Drinks per week _____
Heavy	*Retired*	*High Stress*

Medications	Vitamins/Supplements	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
none	*none*	*none*

Past Medical Conditions

(please check all that apply)

_____ Headaches/Migraines
_____ Neck Pain
_____ Mid Back Pain
_____ Low Back Pain
_____ Hip Pain
_____ Sciatica
_____ Pinched Nerve
_____ Herniated Disc

_____ Joint Replacement
_____ Fused Joints
_____ Arthritis
_____ Osteoporosis
_____ Osteopenia
_____ High Blood Pressure
_____ Pacemaker
_____ Hernia

_____ Heart Disease
_____ Stroke
_____ Cancer
_____ Diabetes
_____ Tumors
_____ Seizure Disorder
_____ Blood/Clotting Disorder
_____ AIDS/HIV

Other _____

Are you pregnant? *Yes* *No* *N/A* If so, how many weeks? _____

Please describe any of the following:

Surgeries _____

Major accidents/injuries _____

Anything else you would like the doctor to know _____

Patient or Guardian Signature _____ Date _____

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Chief Complaint

Reason for today's visit _____

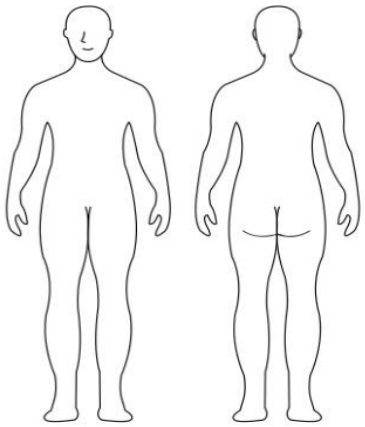
When did your complaint start? _____

What makes the condition worse? _____

What makes the condition better? _____

Please rate your symptoms _____
(1 = none, 10 = severe)

(please mark affected areas)



Type of pain: *Sharp* *Dull* *Aching*

Burning *Numbness* *Tingling*

Stiffness *Swelling*

Does the pain travel? _____

If so, from where to where? _____

Have you seen a chiropractor before? *Yes* *No* If so, how recently? _____

Please describe any other concerns with your chief complaint _____

_____

Are you currently experiencing any of the following:

_____ Headache or neck pain
_____ Dizziness
_____ Fainting
_____ Nausea or vomiting
_____ Double vision
_____ Numbness on one side of the face
_____ Difficulty swallowing
_____ Difficulty speaking
_____ Difficulty walking
_____ Rapid eye movement

(for doctor use only)

Patient or Guardian Signature _____ Date _____

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Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent”, and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations, as well. When providing an adjustment, we use our hands, or an instrument, to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravation of and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and/or hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that is typically caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that the chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare, and is estimated to be related to one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin-induced major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons per year, and risk of death has been estimated as 104 per one million users.

It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion, and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition, and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name _____ Signature _____ Date _____

Parent or Guardian Name _____ Signature _____ Date _____

Witness Name _____ Signature _____ Date _____