

HEALTH HISTORY

To give the Doctor a complete picture of your overall health, please check off ANY of the following symptoms you currently have or have had in the past 6 MONTHS, even if you don't think they are related to the current problem.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Diarrhea/constipation | <input type="checkbox"/> Low back/hip pain |
| <input type="checkbox"/> Leg/knee/foot pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Arm/shoulder/wrist pain | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Buzzing/ringing in ears | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> General fatigue | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Cold feet/hands | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Anxiousness | <input type="checkbox"/> Miscarriage(s) _____ | <input type="checkbox"/> Menstrual pain/PMS | <input type="checkbox"/> Breast pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> IBS/Colitis | <input type="checkbox"/> Painful urination | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Liver/gallbladder disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer _____ |

List all medications and supplements you are taking (including birth control pills): _____

List any surgeries/hospitalizations and include when: _____

List any car accidents and/or major falls/injuries and include when: _____

Do you have a family history of: Heart Disease Stroke Cancer Arthritis Diabetes

Do you personally suffer from any of the above? No Yes, _____

Is there anything else you would like us to know? _____

ABOUT YOUR CARE

Chiropractic provides three types of care:

1. Initial Intensive Care: corrects the most recent layers of damage/injury and usually reduces or eliminates the symptoms.
2. Reconstructive Care: also known as spinal rehabilitation, which corrects the years of damage that occurred when there were few symptoms.
3. Maintenance Care: helps keep you healthy. The Doctor will explain these options to you and help you choose the care that's right for you.

What do you hope to get from today's visit? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Explanation of condition | <input type="checkbox"/> Ability to resume/increase activity | <input type="checkbox"/> Reduce symptoms |
| <input type="checkbox"/> Learn what I can do to help | <input type="checkbox"/> Prevent recurrence | <input type="checkbox"/> Other: _____ |



elements health

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

● **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does **not** establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor’s attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Name (Please Print)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____