PATIENT NAME:_____ DATE OF BIRTH_____

LAST, FIRST, MIDDLE INTIAL

CHIROPRACTIC INTAKE INFORMATION

1. Chiropractic History:

Please list the last chiropractor you have seen.

Name of Doctor:_____ Date last seen:_____

Address:_____ Phone #: _____

Consulted for:_____

2. Reason for consulting a chiropractor today:

____ I have no symptoms and I feel well. I am interested in continuing and improving my good health (please skip to question #4)

____ I have a specific health problem, complaint or illness

How long have you had this pain? ____ Years ____Months ____Weeks

Is this your first episode of this pain? ____Yes ____ No

Current complaint:

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

Average pain level over the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

3. Are you getting better?

Please rate your improvement since starting care for this episode: _____%

Please circle your improvement since starting care for this injury:

No improvement Slight improvement Moderate improvement Greatly improved

Have your abilities to reform your activities of daily living or work activities improved? ____Yes ____No

Explain: _____

_____

4. Is there anything new?

Have you had any new complaints/conditions since starting care? ____Yes ____No

Have you had any re-injuries or events that have prolonged your recovery? ____Yes ____No

Explain: _____

_____

I certify the complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient signature: _____ Date: _____

PATIENT NAME:_____ DATE OF BIRTH_____

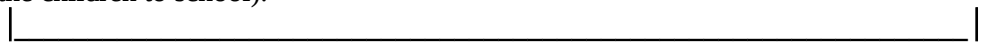
LAST, FIRST, MIDDLE INTIAL

CHIROPRACTIC GENERAL PAIN DISABILITY QUESTIONAIRE

The ratings scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the ***overall*** impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been disrupted or prevented by your pain.

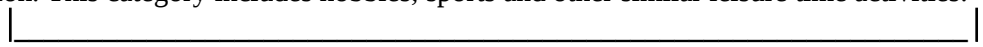
1. Family/ Home Responsibilities. This category refers to activities related to the home or family. It includes chores and duties preformed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

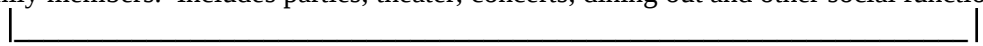
2. Recreation. This category includes hobbies, sports and other similar leisure time activities.



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

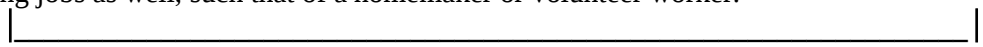
3. Social Activity. This category refers to activities which involve participation with friends and acquaintances other than family members. Includes parties, theater, concerts, dining out and other social functions.



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

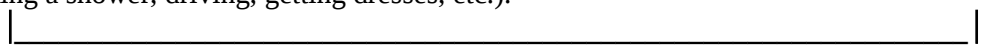
4. Occupation. This category refers to activities that are part of or directly related to one's job. This includes nonpaying jobs as well, such that of a homemaker or volunteer worker.



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

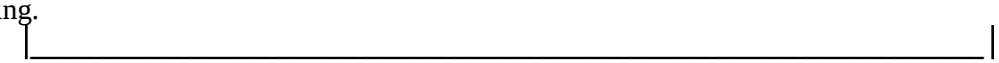
5. Self Care. This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dresses, etc.).



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

6. Life-Support Activity. This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.



0 1 2 3 4 5 6 7 8 9 10

No pain Totally unable to function

TOTAL SCORE: _____ DATE: _____

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Witness Name	**Signature**	**Date**