Integrated Walk In Chiropractic
162 E 29th St , Loveland, CO, 80538
970-481-2940 mywalkinchiro@gmail.com

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Have you consulted a chiropractor before?
○ No ○ Yes **When?**

If so, whom?

Your Last Name

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender
○ Male ○ Female

Address

City

State/Province

ZIP/Postal Code

Child's Name and Age

Home Phone

Cell Phone

Email Address

Emergency Contact

Emergency Contact's Phone

Your Occupation

Primary Care Provider's Name

CONFIDENTIAL HEALTH INFORMATION

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Informed Consent to Chiropractic and or Massage Treatment

The nature of chiropractic treatment: The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation or therapeutic ultrasound may also be used.

The nature of massage therapy treatment: It is my choice to receive massage therapy. I understand that the massage I receive is for the relief of muscular tension, and it should not be construed as a substitute for medical examination, diagnosis, or treatment. I further understand that massage therapists are not qualified to diagnosis or treat illnesses. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of treatments.

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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

- *Self-administered, over-the-counter analgesics and rest.*
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- *Hospitalization:* in conjunction with medical care.
- *Surgery* in conjunction with medical care.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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Risks of remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____	_____	_____
Printed Name	**Signature**	**Date**

_____
Signature of Parent or Guardian
(if a minor)

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PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

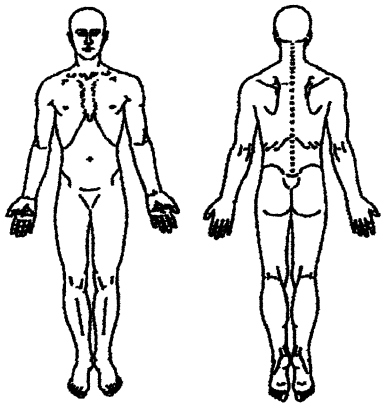
Your First Name _____ **Your Last Name** _____ **Your Middle Name (or Initial)** _____

Your Height _____ **Your Weight** _____

Current symptoms: (Reason for today's visit) _____

1. Onset: (When did it start and how often?) _____

2. Location (Where does it hurt?) Circle the area (s) on the illustration.



3. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other

4. Intensity (How extreme are your current symptoms?)

0 ○○○○○○○○○○ 10

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

○ Constant ○ Come and goes.

_____

6. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

7. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to **worsen** the problem? _____

What tends to **lessen** the problem? _____

8. Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Surgery ○ Ice
- ○ Over-the-counter drugs ○ Acupuncture ○ Heat
- ○ Homeopathic remedies ○ Chiropractic Other _____
- ○ Physical therapy ○ Massage _____

9. What else should Integrated Chiropractic know about your current condition? _____

_____

_____

10. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

This patient history is for:

- ○ New Patient
- ○ Current Patient Periodic Re-evaluation
- ○ Current Patient Additional Complaint/ Exacerbation
- ○ Maintenance Patient (circle one) Exacerbation Re-Occurrence New Episode
- ○ Inactive Patient (circle one) Exacerbation Re-Occurrence New Episode
- ○ Injury

Consultation Notes

PATIENT HISTORY

Doctor's Initials _____

11. Family Health History: (Circle all that apply)

○ Osteoarthritis ○ Rheumatoid Arthritis ○ Heart Disease ○ High Blood Pressure ○ Diabetes ○ Cancer ○ Stroke ○ Seizures

12. Review of systems (Circle all that apply)

a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc. _____

b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc. _____

c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc. _____

d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc. _____

e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc. _____

f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc. _____

g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc. _____

h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc. _____

i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc. _____

j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc. _____

13. Past or Current Allergies, illnesses, operations, injuries or treatments _____

_____

14.Medications: (Please list all prescription and over-the-counter) _____

_____

15. Social History (Tell Integrated Chiropractic about your health habits and stress levels.)

Alcohol use ○ Daily ○ Weekly How much?_____

Coffee use ○ Daily ○ Weekly How much?_____

Tobacco use ○ Daily ○ Weekly How much?_____

Exercising ○ Daily ○ Weekly How much?_____

Pain relievers ○ Daily ○ Weekly How much?_____

Soft drinks ○ Daily ○ Weekly How much?_____

Water intake ○ Daily ○ Weekly How much?_____

Hobbies: _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

Integrated Chiropractic