

Red Rock Chiropractic Center

New Patient Basic Information

PATIENT INFORMATION	
First name:	_____
Last name:	_____
Preferred name (Nickname):	_____
Address:	_____
City:	_____ State: _____ Zip: _____
Sex:	<input type="checkbox"/> M <input type="checkbox"/> F Age: _____
Birthdate:	___/___/___ SS# ___-___-___
Home phone:	(____)____-_____
Cell phone:	(____)____-_____
E-mail:	_____

SPOUSE OR RELATIVE INFORMATION	
Marital status:	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor
Spouse first name:	_____
Spouse last name:	_____
Spouse employer:	_____
Employment status:	<input type="checkbox"/> Full-time <input type="checkbox"/> Not employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired
Spouse work phone:	(____)____-_____
Spouse cell phone:	(____)____-_____

EMPLOYMENT STATUS	
Employer:	_____
Employer address:	_____
Employer city:	_____
Employer state:	_____ Employer zip: _____
Employer phone:	(____)____-_____
Employment status:	<input type="checkbox"/> Full-time <input type="checkbox"/> Not employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired

EMERGENCY CONTACT INFORMATION	
Emergency contact name:	_____
Emergency contact phone:	(____)____-_____
Relationship to patient:	_____

PRIMARY INSURANCE INFORMATION	
Insurance company:	_____
Subscriber:	_____
Relationship to patient:	_____
Policy number:	_____
Group number:	_____
Person responsible for payment:	_____
Deductible:	_____ Amt met this year: _____
Co-pay:	_____

SECONDARY INSURANCE INFORMATION	
Insurance company:	_____
Subscriber:	_____
Relationship to patient:	_____
Policy number:	_____
Group number:	_____
Person responsible for payment:	_____
Deductible:	_____ Amt met this year: _____
Co-pay:	_____

* If the patient will be using insurance benefits, please sign and date the form below.

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Red Rock Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

I request that payment of authorized Medicare benefits be made of my behalf to Red Rock Chiropractic Center for any services furnished to me. I authorize any holder of medical information about me to release to the health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Responsible Party Signature

Date

New Patient Health Questionnaire

We strive to be as thorough as possible

Primary Complaint	Secondary Complaint	Tertiary Complaint
Briefly describe complaint: <hr/> <hr/>	Briefly describe complaint: <hr/> <hr/>	Briefly describe complaint: <hr/> <hr/>
Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ____/____/____	Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ____/____/____	Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ____/____/____
Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other
To whom have you made an accident report? <input type="checkbox"/> Auto insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work comp <input type="checkbox"/> Other	To whom have you made an accident report? <input type="checkbox"/> Auto insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work comp <input type="checkbox"/> Other	To whom have you made an accident report? <input type="checkbox"/> Auto insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work comp <input type="checkbox"/> Other
Date you first noticed your symptoms: ____/____/____	Date you first noticed your symptoms: ____/____/____	Date you first noticed your symptoms: ____/____/____
<p style="text-align: center;">PAIN SCALE (X)</p> <p>BEST WORST</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p style="text-align: center;">PAIN SCALE (X)</p> <p>BEST WORST</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p style="text-align: center;">PAIN SCALE (X)</p> <p>BEST WORST</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>
Please check the box below that best represents how much of the day you feel pain or your symptom(s) for the listed reason: <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%	Please check the box below that best represents how much of the day you feel pain or your symptom(s) for the listed reason: <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%	Please check the box below that best represents how much of the day you feel pain or your symptom(s) for the listed reason: <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
Is there a certain time of day that the pain is worse? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____	Is there a certain time of day that the pain is worse? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____	Is there a certain time of day that the pain is worse? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____
Does your pain stay in one spot or does it radiate to other areas of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, briefly describe where the pain goes to: _____ _____	Does your pain stay in one spot or does it radiate to other areas of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, briefly describe where the pain goes to: _____ _____	Does your pain stay in one spot or does it radiate to other areas of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, briefly describe where the pain goes to: _____ _____
Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please check ALL that describes your current symptoms:

- Dull Sharp
- Aching Throbbing
- Burning Tingling
- Deep Stabbing
- Pinprick Numbness
- Radiating Aching
- Sharp with movement

Please check ALL that aggravate your condition:

- Driving Breathing
- Walking Coughing
- Sitting Sleeping
- Bending Working
- Standing Exercising
- Other _____

What makes your condition better?

- Chiropractic Stretching
- Rest Movement
- Lying down Heat
- Ice Sitting
- Standing Ibuprofen
- Other _____

Have you had this current complaint in the past? Yes No
If Yes, when? ____ / ____ / ____

Have you seen any other providers for your symptoms? Yes No
If Yes, please list name & contact information: _____

What other treatments have you had for this condition?

- Chiropractic Neurologist
- Massage Medication
- Physical therapist Surgery
- Other _____

Please check ALL that describes your current symptoms:

- Dull Sharp
- Aching Throbbing
- Burning Tingling
- Deep Stabbing
- Pinprick Numbness
- Radiating Aching
- Sharp with movement

Please check ALL that aggravate your condition:

- Driving Breathing
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What makes your condition better?

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- Standing Ibuprofen
- Other _____

Have you had this current complaint in the past? Yes No
If Yes, when? ____ / ____ / ____

Have you seen any other providers for your symptoms? Yes No
If Yes, please list name & contact information: _____

What other treatments have you had for this condition?

- Chiropractic Neurologist
- Massage Medication
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Please check ALL that describes your current symptoms:

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- Aching Throbbing
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Please check ALL that aggravate your condition:

- Driving Breathing
- Walking Coughing
- Sitting Sleeping
- Bending Working
- Standing Exercising
- Other _____

What makes your condition better?

- Chiropractic Stretching
- Rest Movement
- Lying down Heat
- Ice Sitting
- Standing Ibuprofen
- Other _____

Have you had this current complaint in the past? Yes No
If Yes, when? ____ / ____ / ____

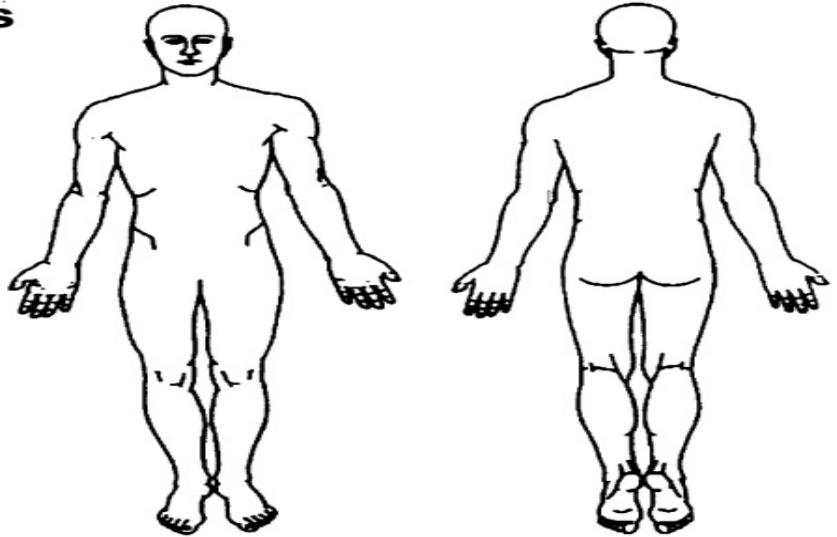
Have you seen any other providers for your symptoms? Yes No
If Yes, please list name & contact information: _____

What other treatments have you had for this condition?

- Chiropractic Neurologist
- Massage Medication
- Physical therapist Surgery
- Other _____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness



MEDICATIONS USED	ALLERGIES	VITAMINS/HERBS/MINERALS

MEDICATION ALLERGIES: _____

PLEASE LIST PRIMARY CARE PHYSICIAN AND PHONE NUMBER: _____

**PLEASE LIST ALL ACCIDENTS, INJURIES, FRACTURES, & HOSPITALIZATIONS.
 IF NONE PLEASE WRITE: NONE**

Accidents, Injuries, Fractures (Dates): _____

Hospitalizations (Dates): _____

Have you had any previous diagnostic imaging? X-rays MRI Bone density Other _____

Please list date of last:
 Physical exam: ___/___/___ Spinal exam: ___/___/___ Spinal x-ray: ___/___/___
 MRI: ___/___/___ CT-scan: ___/___/___ Bone scan: ___/___/___

DAILY STRESS SCALE

Low High
0 1 2 3 4 5 6 7 8 9 10

Have you ever sought help for a mental health issue? Yes No

SLEEPING PATTERN

Hours of sleep per night? _____ Hours

Please indicate your sleep quality:

Excellent Good Fair Poor

Sleep interrupted _____ times/night

How long? _____ weeks, _____ months, _____ years

Have you ever been to a chiropractor before? Yes No

How did you hear about us? Website Newspaper Radio Phone book M.D.

Massage therapist Referral _____

WOMEN ONLY:

Are you pregnant? Yes No Unsure

If pregnant, what is your due date? ____/____/____

Health History

Place a mark on the "Yes" to indicate if you have had any of the following:

Interested in quitting smoking?	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> Yes	Psychiatric illness	<input type="checkbox"/> Yes
Interested in weight loss?	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> Yes	Rheumatoid Arthritis	<input type="checkbox"/> Yes
Interested in exercise program?	<input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> Yes	Rheumatoid fever	<input type="checkbox"/> Yes
Alcoholism	<input type="checkbox"/> Yes	Hypertension	<input type="checkbox"/> Yes	Skin disorder	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> Yes	Multiple Sclerosis	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> Yes	Polio	<input type="checkbox"/> Yes	Other _____	<input type="checkbox"/> Yes

SURGERIES:

Appendectomy Date: ___/___/___	<input type="checkbox"/> Yes	Laminectomies Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes
Cardiovascular procedure Date: ___/___/___	<input type="checkbox"/> Yes	Radical prostatectomy Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes
Cervical disc procedure Date: ___/___/___	<input type="checkbox"/> Yes	Prostate surgery Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes
Hysterectomy Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes
Joint replacement Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes	Other _____ Date: ___/___/___	<input type="checkbox"/> Yes

SOCIAL HISTORY:

Caffeine used	<input type="checkbox"/> Often <input type="checkbox"/> Occasionally	Exercise	<input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Drink alcohol	<input type="checkbox"/> Often <input type="checkbox"/> Occasionally	Experience stress	<input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Chew tobacco	<input type="checkbox"/> Often <input type="checkbox"/> Occasionally	Wear seatbelt	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Never
Smoke	<input type="checkbox"/> 1 pack or less per day <input type="checkbox"/> More than 1 pack per day		

FAMILY HISTORY:

Alzheimer's	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Heart problems	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Arthritis	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	High blood pressure	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Cholesterol	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Osteoporosis	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Cancer	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Psychiatric	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Diabetes	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Stroke	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Epilepsy	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Thyroid disorder	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling

SUBSTANCE USE:

Alcohol	<input type="checkbox"/> Past <input type="checkbox"/> Present	Crystal meth	<input type="checkbox"/> Past <input type="checkbox"/> Present
Amphetamines	<input type="checkbox"/> Past <input type="checkbox"/> Present	Heroin	<input type="checkbox"/> Past <input type="checkbox"/> Present
Barbiturates	<input type="checkbox"/> Past <input type="checkbox"/> Present	Marijuana	<input type="checkbox"/> Past <input type="checkbox"/> Present
Cocaine	<input type="checkbox"/> Past <input type="checkbox"/> Present	Other _____	

DO YOU HAVE CHILDREN?

Male children	<input type="checkbox"/> under 6 years	<input type="checkbox"/> under 10 years	<input type="checkbox"/> under 19 years
Female children	<input type="checkbox"/> under 6 years	<input type="checkbox"/> under 10 years	<input type="checkbox"/> under 19 years

OCCUPATIONAL ACTIVITIES:

Administration	<input type="checkbox"/>	Healthcare	<input type="checkbox"/>	Military	<input type="checkbox"/>
Business owner	<input type="checkbox"/>	Heavy equipment operator	<input type="checkbox"/>	Police/fire	<input type="checkbox"/>
Clerical/secretarial	<input type="checkbox"/>	Heavy manual labor	<input type="checkbox"/>	Professional services	<input type="checkbox"/>
Computer user	<input type="checkbox"/>	Home services	<input type="checkbox"/>	Retail worker	<input type="checkbox"/>
Construction	<input type="checkbox"/>	Household	<input type="checkbox"/>	Teacher	<input type="checkbox"/>
Daycare/childcare	<input type="checkbox"/>	Light manual labor	<input type="checkbox"/>	Truck driver	<input type="checkbox"/>
Executive/legal	<input type="checkbox"/>	Manufacturing	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
Food service industry	<input type="checkbox"/>	Medium manual labor	<input type="checkbox"/>		

RECREATIONAL ACTIVITIES:

Backpacking	<input type="checkbox"/>	Racket ball	<input type="checkbox"/>	Tennis	<input type="checkbox"/>
Biking	<input type="checkbox"/>	Running	<input type="checkbox"/>	Walking	<input type="checkbox"/>
Boating	<input type="checkbox"/>	Skiing	<input type="checkbox"/>	Weight lifting	<input type="checkbox"/>
Football	<input type="checkbox"/>	Soccer	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
Golf	<input type="checkbox"/>	Swimming	<input type="checkbox"/>		

Review of Systems

CARDIOVASCULAR:			
High cholesterol	<input type="checkbox"/> Present <input type="checkbox"/> Past	Pace maker	<input type="checkbox"/> Present <input type="checkbox"/> Past
High blood pressure	<input type="checkbox"/> Present <input type="checkbox"/> Past	Poor circulation	<input type="checkbox"/> Present <input type="checkbox"/> Past
Low blood pressure	<input type="checkbox"/> Present <input type="checkbox"/> Past	Cold feet or hands	<input type="checkbox"/> Present <input type="checkbox"/> Past
Aortic aneurism	<input type="checkbox"/> Present <input type="checkbox"/> Past	Discolored feet/hands	<input type="checkbox"/> Present <input type="checkbox"/> Past
Heart disease	<input type="checkbox"/> Present <input type="checkbox"/> Past	Hot feet/hands	<input type="checkbox"/> Present <input type="checkbox"/> Past
Vascular disease	<input type="checkbox"/> Present <input type="checkbox"/> Past	Leg cramps	<input type="checkbox"/> Present <input type="checkbox"/> Past
Heart attack	<input type="checkbox"/> Present <input type="checkbox"/> Past	Calf pain	<input type="checkbox"/> Present <input type="checkbox"/> Past
Chest pain	<input type="checkbox"/> Present <input type="checkbox"/> Past	Varicose veins	<input type="checkbox"/> Present <input type="checkbox"/> Past
Irregular heartbeat	<input type="checkbox"/> Present <input type="checkbox"/> Past	Swelling of legs	<input type="checkbox"/> Present <input type="checkbox"/> Past

GENITOURINARY:			
Difficulty urinating	<input type="checkbox"/> Present <input type="checkbox"/> Past	Decreased urination	<input type="checkbox"/> Present <input type="checkbox"/> Past
Burning urination	<input type="checkbox"/> Present <input type="checkbox"/> Past	Urinary infection	<input type="checkbox"/> Present <input type="checkbox"/> Past
Blood in urine	<input type="checkbox"/> Present <input type="checkbox"/> Past	Kidney disease	<input type="checkbox"/> Present <input type="checkbox"/> Past
Incontinence	<input type="checkbox"/> Present <input type="checkbox"/> Past	Genital infection	<input type="checkbox"/> Present <input type="checkbox"/> Past
Foul odor of urine	<input type="checkbox"/> Present <input type="checkbox"/> Past	Lower side pain	<input type="checkbox"/> Present <input type="checkbox"/> Past
Frequent urination	<input type="checkbox"/> Present <input type="checkbox"/> Past	Kidney stone	<input type="checkbox"/> Present <input type="checkbox"/> Past

HEMATOLOGIC/LYMPHATIC:			
Hepatitis	<input type="checkbox"/> Present <input type="checkbox"/> Past	Easy bruising	<input type="checkbox"/> Present <input type="checkbox"/> Past
Blood clots	<input type="checkbox"/> Present <input type="checkbox"/> Past	Easy bleeding	<input type="checkbox"/> Present <input type="checkbox"/> Past
Cancer	<input type="checkbox"/> Present <input type="checkbox"/> Past	Fevers/ Chills/ Sweats	<input type="checkbox"/> Present <input type="checkbox"/> Past

RESPIRATORY:			
Shortness of breath	<input type="checkbox"/> Present <input type="checkbox"/> Past	Emphysema	<input type="checkbox"/> Present <input type="checkbox"/> Past
Asthma	<input type="checkbox"/> Present <input type="checkbox"/> Past	Cough/Wheezing	<input type="checkbox"/> Present <input type="checkbox"/> Past
Pneumonia	<input type="checkbox"/> Present <input type="checkbox"/> Past	Coughing of phlegm	<input type="checkbox"/> Present <input type="checkbox"/> Past
Tuberculosis	<input type="checkbox"/> Present <input type="checkbox"/> Past	Coughing up blood	<input type="checkbox"/> Present <input type="checkbox"/> Past

EARS/NOSE/THROAT:			
ringing in ears	<input type="checkbox"/> Present <input type="checkbox"/> Past	Bleeding gums	<input type="checkbox"/> Present <input type="checkbox"/> Past
Frequent infection	<input type="checkbox"/> Present <input type="checkbox"/> Past	Cold sores	<input type="checkbox"/> Present <input type="checkbox"/> Past
Hearing loss	<input type="checkbox"/> Present <input type="checkbox"/> Past	Dentures	<input type="checkbox"/> Present <input type="checkbox"/> Past
Drainage	<input type="checkbox"/> Present <input type="checkbox"/> Past	Difficulty swallowing	<input type="checkbox"/> Present <input type="checkbox"/> Past
Dizziness	<input type="checkbox"/> Present <input type="checkbox"/> Past	Sore throat	<input type="checkbox"/> Present <input type="checkbox"/> Past
Ear pain	<input type="checkbox"/> Present <input type="checkbox"/> Past	Jaw pain	<input type="checkbox"/> Present <input type="checkbox"/> Past
Post nasal drip	<input type="checkbox"/> Present <input type="checkbox"/> Past	Changes in taste	<input type="checkbox"/> Present <input type="checkbox"/> Past
Nosebleed	<input type="checkbox"/> Present <input type="checkbox"/> Past	Swelling	<input type="checkbox"/> Present <input type="checkbox"/> Past
Sinus infection	<input type="checkbox"/> Present <input type="checkbox"/> Past	Hoarseness	<input type="checkbox"/> Present <input type="checkbox"/> Past

EYES:			
Changes in vision	<input type="checkbox"/> Present <input type="checkbox"/> Past	Cataracts	<input type="checkbox"/> Present <input type="checkbox"/> Past
Glasses/contacts	<input type="checkbox"/> Present <input type="checkbox"/> Past	Sensitivity to light	<input type="checkbox"/> Present <input type="checkbox"/> Past
Blurred vision	<input type="checkbox"/> Present <input type="checkbox"/> Past	Flashes in vision	<input type="checkbox"/> Present <input type="checkbox"/> Past
Double vision	<input type="checkbox"/> Present <input type="checkbox"/> Past	Spots in vision	<input type="checkbox"/> Present <input type="checkbox"/> Past
Glaucoma	<input type="checkbox"/> Present <input type="checkbox"/> Past		

INTEGUMENTARY:			
Rashes	<input type="checkbox"/> Present <input type="checkbox"/> Past	Skin ulcers	<input type="checkbox"/> Present <input type="checkbox"/> Past
Warts	<input type="checkbox"/> Present <input type="checkbox"/> Past	Peeling	<input type="checkbox"/> Present <input type="checkbox"/> Past
Brittle nails	<input type="checkbox"/> Present <input type="checkbox"/> Past	Skin disease	<input type="checkbox"/> Present <input type="checkbox"/> Past
Changes in moles	<input type="checkbox"/> Present <input type="checkbox"/> Past	Eczema	<input type="checkbox"/> Present <input type="checkbox"/> Past
Itching	<input type="checkbox"/> Present <input type="checkbox"/> Past	Psoriasis	<input type="checkbox"/> Present <input type="checkbox"/> Past

ALLERGIC/IMMUNOLOGIC:			
Hives	<input type="checkbox"/> Present <input type="checkbox"/> Past	Allergy shots	<input type="checkbox"/> Present <input type="checkbox"/> Past
Immune disorder	<input type="checkbox"/> Present <input type="checkbox"/> Past	Cortisone use	<input type="checkbox"/> Present <input type="checkbox"/> Past
HIV/AIDS	<input type="checkbox"/> Present <input type="checkbox"/> Past		

GASTROINTESTINAL:			
Gas	<input type="checkbox"/> Present <input type="checkbox"/> Past	Diarrhea	<input type="checkbox"/> Present <input type="checkbox"/> Past
Heartburn/Indigestion	<input type="checkbox"/> Present <input type="checkbox"/> Past	Constipation	<input type="checkbox"/> Present <input type="checkbox"/> Past
Abdominal pain	<input type="checkbox"/> Present <input type="checkbox"/> Past	Bloody stools	<input type="checkbox"/> Present <input type="checkbox"/> Past
Ulcers	<input type="checkbox"/> Present <input type="checkbox"/> Past	Hemorrhoids	<input type="checkbox"/> Present <input type="checkbox"/> Past
Poor appetite	<input type="checkbox"/> Present <input type="checkbox"/> Past	Gallbladder problems	<input type="checkbox"/> Present <input type="checkbox"/> Past
Nausea/Vomiting	<input type="checkbox"/> Present <input type="checkbox"/> Past	Liver problems	<input type="checkbox"/> Present <input type="checkbox"/> Past
Bowel problems	<input type="checkbox"/> Present <input type="checkbox"/> Past		

MUSCULOSKELETAL:			
Masses	<input type="checkbox"/> Present <input type="checkbox"/> Past	Deformity	<input type="checkbox"/> Present <input type="checkbox"/> Past
Swelling	<input type="checkbox"/> Present <input type="checkbox"/> Past	Bone pain	<input type="checkbox"/> Present <input type="checkbox"/> Past
Joint stiffness	<input type="checkbox"/> Present <input type="checkbox"/> Past	Broken bones	<input type="checkbox"/> Present <input type="checkbox"/> Past
Joint pain	<input type="checkbox"/> Present <input type="checkbox"/> Past	Dislocations	<input type="checkbox"/> Present <input type="checkbox"/> Past
Muscle ache	<input type="checkbox"/> Present <input type="checkbox"/> Past	Joints replaced	<input type="checkbox"/> Present <input type="checkbox"/> Past
Arthritis	<input type="checkbox"/> Present <input type="checkbox"/> Past	Gout	<input type="checkbox"/> Present <input type="checkbox"/> Past
Osteoporosis	<input type="checkbox"/> Present <input type="checkbox"/> Past	Muscle weakness	<input type="checkbox"/> Present <input type="checkbox"/> Past

ENDOCRINE:			
Thyroid disease	<input type="checkbox"/> Present <input type="checkbox"/> Past	Menopausal	<input type="checkbox"/> Present <input type="checkbox"/> Past
Diabetes	<input type="checkbox"/> Present <input type="checkbox"/> Past	Menstrual problems	<input type="checkbox"/> Present <input type="checkbox"/> Past
Hair loss	<input type="checkbox"/> Present <input type="checkbox"/> Past		

NEUROLOGICAL:			
Severe Headaches	<input type="checkbox"/> Present <input type="checkbox"/> Past	Tingling sensations	<input type="checkbox"/> Present <input type="checkbox"/> Past
Spinning/Balance	<input type="checkbox"/> Present <input type="checkbox"/> Past	Numbness	<input type="checkbox"/> Present <input type="checkbox"/> Past
Stroke	<input type="checkbox"/> Present <input type="checkbox"/> Past	Weakness	<input type="checkbox"/> Present <input type="checkbox"/> Past
Head injury	<input type="checkbox"/> Present <input type="checkbox"/> Past	Difficulty walking	<input type="checkbox"/> Present <input type="checkbox"/> Past
Fainting	<input type="checkbox"/> Present <input type="checkbox"/> Past	Poor coordination	<input type="checkbox"/> Present <input type="checkbox"/> Past
Blacking out	<input type="checkbox"/> Present <input type="checkbox"/> Past	Brain aneurysm	<input type="checkbox"/> Present <input type="checkbox"/> Past
Seizures	<input type="checkbox"/> Present <input type="checkbox"/> Past	Pinched nerves	<input type="checkbox"/> Present <input type="checkbox"/> Past
Parkinson's disease	<input type="checkbox"/> Present <input type="checkbox"/> Past	Carpal tunnel	<input type="checkbox"/> Present <input type="checkbox"/> Past

PSYCHIATRIC:			
Depression	<input type="checkbox"/> Present <input type="checkbox"/> Past	Unusual stress	<input type="checkbox"/> Present <input type="checkbox"/> Past
Anxiety disorder	<input type="checkbox"/> Present <input type="checkbox"/> Past	Mood swings	<input type="checkbox"/> Present <input type="checkbox"/> Past

CONSTITUTIONAL:			
Weight loss/gain	<input type="checkbox"/> Present <input type="checkbox"/> Past	Difficulty sleeping	<input type="checkbox"/> Present <input type="checkbox"/> Past
Energy level problem	<input type="checkbox"/> Present <input type="checkbox"/> Past		

Informed Consent Form

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. Other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings. Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common ¹,

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare ²

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome³ (1 case per 100 million adjustments)
- Compromise of vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 42 and is higher for those older than 42 when seeing a medical doctor.^{4,5} These findings suggest that neither chiropractic or medical care is the cause, but rather because patients with a dissection in progress have symptoms of headache or neck pain they seek care from a health care provider. Please indicate to your doctor if you have a headache or neck pain that is the worst you have ever felt.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.⁶
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.⁷

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Senstad O, Leboeuf-Yde C, Borchgrevink CF. Side-effects of chiropractic spinal manipulation: types frequency, discomfort and course. *Scand J Prim Health Care*. Mar 1996;14(1):50-53.
2. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine*. Oct 1 2007;32(21):2375-2378; discussion 2379.
3. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. *Ann Intern Med*. Oct 1 1992;117(7):590-598.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine*. Feb 15 2008;33(4 Suppl):S170-175.
5. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*. Feb 15 2008;33(4 Suppl):S176-183.
6. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S153-169.
7. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S75-82.

Please check any appropriate boxes if it is true for you to help us determine possible risk factors:

QUESTION	YES	DOCTORS'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	<input type="checkbox"/>	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	<input type="checkbox"/>	
Do you take corticosteroids (e.g. prednisone)?	<input type="checkbox"/>	
Have you been diagnosed with a compression fracture(s) of the spine?	<input type="checkbox"/>	
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	
Do you have any metal implants?	<input type="checkbox"/>	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	<input type="checkbox"/>	
If yes, about how much do you take daily? _____	<input type="checkbox"/>	
Do you take warfarin (Coumadin), heparin, or other similar "blood thinners"?	<input type="checkbox"/>	
Have you ever been diagnosed with any of the following disorders/diseases?	<input type="checkbox"/>	
• Rheumatoid arthritis	<input type="checkbox"/>	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	<input type="checkbox"/>	
• Giant cell arteritis (temporal arteritis)	<input type="checkbox"/>	
• Osteogenesis imperfect	<input type="checkbox"/>	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	<input type="checkbox"/>	
• Medial cystic necrosis (cystic mucoid degeneration)	<input type="checkbox"/>	
• Bechet's disease	<input type="checkbox"/>	
• Fibromuscular dysplasia	<input type="checkbox"/>	
Have you ever become dizzy or lost consciousness when turning your head?	<input type="checkbox"/>	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	<input type="checkbox"/>	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	<input type="checkbox"/>	
Have you been diagnosed with spondylolithesis?	<input type="checkbox"/>	
Have you had any of the following problems?	<input type="checkbox"/>	
• Sudden weakness in the arms or legs?	<input type="checkbox"/>	
• Numbness in the genital area?	<input type="checkbox"/>	
• Recent inability to urinate or lack of control when urinating?	<input type="checkbox"/>	

I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition. I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____
(if appropriate)

DOCTOR'S SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S NAME _____
LAST FIRST INITIAL

ADDRESS _____
STREET CITY STATE ZIP

PHONE (_____) _____ BIRTH DATE _____ SNN _____

The following individual or organization is authorized to make the disclosure:

1. _____ NAME	2. _____ NAME	3. _____ NAME
_____ ADDRESS	_____ ADDRESS	_____ ADDRESS
_____ CITY STATE ZIP	_____ CITY STATE ZIP	_____ CITY STATE ZIP
_____ PHONE NUMBER	_____ PHONE NUMBER	_____ PHONE NUMBER
_____ FAX NUMBER	_____ FAX NUMBER	_____ FAX NUMBER

The type of information to be used or disclosed is as follows:

- | | |
|--|--|
| <input type="checkbox"/> X-RAYS (CD/Films) | <input type="checkbox"/> NECK (CERVICAL SPINE) |
| <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> MID-BACK (THORACIC SPINE) |
| <input type="checkbox"/> TREATMENT NOTES | <input type="checkbox"/> LOW BACK (LUMBAR SPINE) |
| <input type="checkbox"/> OTHER REMARKS _____ | |

This information may be disclosed to and used by the following organization:

KYLE J. PANKONIN, D.C.
RED ROCK CHIROPRACTIC CENTER
202 MAIN STREET
PO BOX 517
LAMBERTON, MN 56152
PHONE: 507-752-7650
FAX: 507-752-7635

The reason for disclosure of this information is for the following reason:

- Continued Healthcare Personal Other _____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the medical record department. I understand the revocation will not apply to:

- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

SIGNED _____ DATE _____
(IF NOT PATIENT, STATE RELATIONSHIP)