Northwest Chiropractic Returning Patient Update

Today's Date _____ First Name: _____ Last Name: _____

Nick Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Preferred Communication: **email** / **phone** / **text**

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Current Medications

Medication	Reason	Start Date

Date of last physical examination: _____

What are your hobbies? _____

MAJOR COMPLAINT

1. What is your Major complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

____ Frequently (51-75% of the day) ____ Occasionally (26-50% of the day) ____ Intermittently (0-25% of the day)

6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

   (0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

COMPLAINT #2

1. What is your second complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

___ Frequently (51-75% of the day) ___ Occasionally (26-50% of the day) ___ Intermittently (0-25% of the day)

6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

   (0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

COMPLAINT #3

1. What is your third complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

____ Frequently (51-75% of the day) ____ Occasionally (26-50% of the day) ____ Intermittently (0-25% of the day)

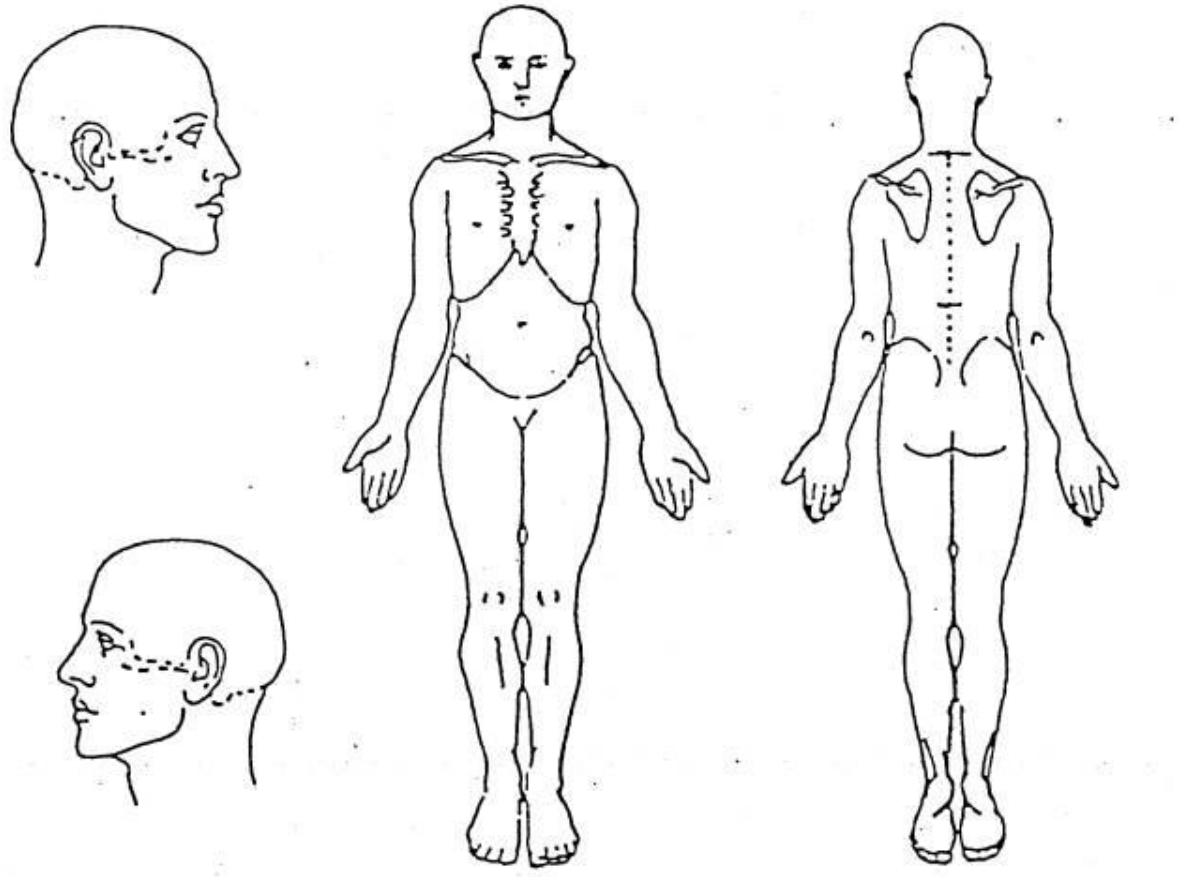
6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

   (0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



CANCELLATION POLICY

We require a 12-hour notice for cancellations. If we do not receive notice of cancellation before your scheduled appointment, we will assess a $25 NO SHOW fee. In order to stay on time and give each patient their scheduled time, we reserve the right to reschedule your appointment if you are more than 10 minutes late.

I have read and understand the cancellation policy.

_____

Patient Signature

INFORMED CONSENT

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my 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.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to some if not all the following procedures:

Spinal manipulative therapy, palpitation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, Electrical Stim, Radiographic studies, mechanical traction.

Other: (Please explain) _____

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. I 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 I 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.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

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

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which mas 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kelly McLaurin and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient’s Name

_____
Signature

Dated: _____

_____
Doctor’s Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)