CARIBBEAN
CHIROPRACTIC CENTER

LAST VISIT: _____ NP / REACT TODAY'S DATE: _____

DEMOGRAPHIC INFORMATION:

Name:_____ **D.O.B**.___/_____/_____ __ __ _ **Age**:_____

Phone:_____-_____-_____ **Ok to send text reminders?** ☐Yes ☐No

Mailing Address_____ **State:** **ZIP:**_____

Email Address:_____@_____

☐Male ☐Female ☐Unspecified **Marital Status** ☐Single ☐Married ☐Other:_____

Number of children/ages:_____

How did you hear about us? ☐Friend ☐Relative ☐Internet ☐Other: _____

EMPLOYMENT INFORMATION:

☐Full Time Employed ☐Part Time Employed ☐Full Time Student ☐Part Time Student ☐Retired ☐Unemployed

Occupation:_____

Name/Location of employer:_____

EMERGENCY CONTACT NAME/NUMBER:

Do you have medical insurance: ☐Yes ☐ No

Family Physician:_____ Phone ----------__ __ __ __

May we share your information with the above physician for coordinated care? ☐Yes ☐No

IS TODAY'S VISIT RELATED TO A WORK OR AUTO INJURY? ☐ Yes ☐ No

HEALTH HISTORY:

1. In general, would you say your health is: ☐Excellent ☐Very good ☐ Good ☐ Fair ☐ Poor
2. Have you had this problem before:
   ☐Yes ☐No
3. Was treatment provided: ☐ No ☐ Yes If yes, by whom:
4. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ No ☐ Yes If yes, explain:
5. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**?
   ☐ No ☐ Yes If yes, explain:

6. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

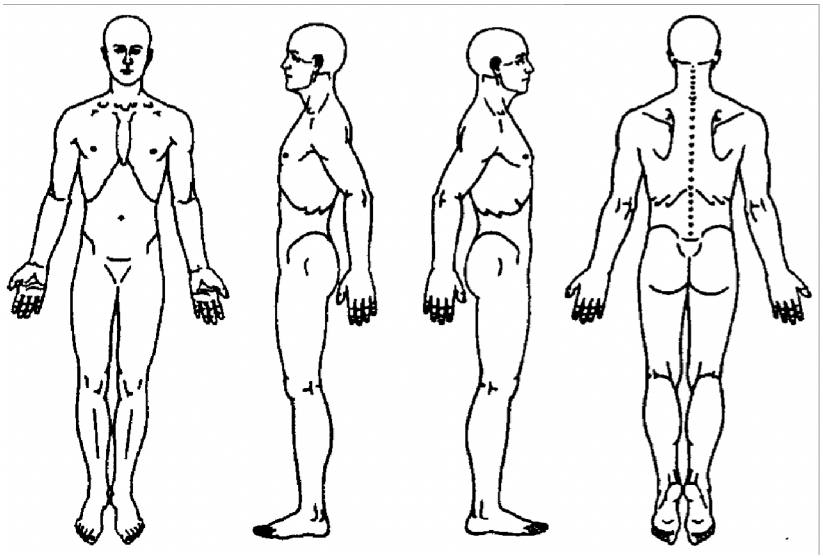
Date	Injury/Fracture/Illness/Surgery	Treatment	Results

PATIENT SYMPTOMS:

Please describe why you are here:_____

_____

_____



Please Use Symbols to Mark Areas of Discomfort:

+++++ Burning

XXXXX Dull Ache

**** Numbness/Tingling

0000 Stabbing/Sharp

==== Throbbing

PAIN LEVEL:

Within the last 24 hours:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Extreme Pain
Within the last week:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Extreme Pain

What caused the pain:_____

When did it start:_____Is the pain: ☐Intermittent ☐Constant

Is the pain worse: ☐Morning ☐Afternoon ☐Evening ☐Night ☐All Day

Is the pain getting: ☐Better ☐Worse ☐Staying the same

What makes your pain worse:_____

What makes your pain better:_____

Please describe any secondary issues:_____

Please indicate any activities that interferes with your ability to function:

☐Sitting	☐Rising Out of Chair	☐Standing	☐Walking
☐Lying Down	☐Bending Over	☐Climbing Stairs	☐Down Stairs
☐Computer	☐Getting In/Out of Car	☐Driving Car	☐Caring for Family
☐Household Chores	☐Lifting Objects	☐Reaching Overhead	☐Showering/Bathing
☐Dressing Myself	☐Love Life	☐Getting to Sleep	☐Staying Asleep
☐Concentrating	☐Exercising	☐Yard Work	☐Occupation

☐Other:

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Mark Y for Yes, N for No)

1.___Eyes
2.___Ears, Nose, Mouth, Throat
3.___Heart
4.___Lungs/ Breathing
5.___Intestines/Bowels
6.___Urinary
7.___Muscles
8.___Nerves
9.___Joints/Bones
10.___Skin
11.___Kidneys
12.___Liver
13.___Digestion
14.___Blood
15.___Allergies
16.___Psychological/Emotional
17.___Gynecological/Menstrual/Breast
18.___Prostate/Testicular/Penile

Please explain any above **YES** answers:

_____
_____
_____
_____
_____

Family History:
Please mark if anyone in your immediate family has:
☐Cancer ☐Diabetes ☐Heart Disease

Social History:
Recreational Activities (Hobbies): _____

Alcohol Use: ☐Daily ☐Weekly How Much
Coffee Use: ☐Daily ☐Weekly How Much
Tobacco Use: ☐Daily ☐Weekly How Much
Pain Killers: ☐Daily ☐Weekly How Much
Soft Drinks: ☐Daily ☐Weekly How Much
Water Intake: ☐Daily ☐Weekly How Much
Exercise: ☐Daily ☐Weekly How Much____

Meditation/Prayer: ☐Yes. ☐No
Job Satisfaction: ☐Yes ☐No
Financial Stability : ☐Yes ☐No
Recreational Drug Use: ☐Yes ☐No

Medications:
Any current medications you are taking (including supplements):
_____

Any past medications you have taken (including supplements):
_____

Is there anything else we should know about this problem or in your health history that has not been addressed?
_____
_____
_____

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million to 1 in 10 million will experience stroke. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. You are being informed of the possibility regardless of the extreme remote chance.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Other treatments including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery may be reasonable alternative procedures or treatment of my condition including, Medications. Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

RIGHTS: As a client you have the right to receive physiotherapy, massage therapy and acupuncture care services which are pertinent to your specific needs, to seek information about those services and to receive services which the therapist is trained to provide. You have the right to be aware of the goals of the therapy session and to understand any follow up care, exercises and daily living information that will be a part of your treatment. You also have the right to discuss the length and cost of the treatment session.

CONFIDENTIALITY: With limited exceptions as defined by law, the information discussed in your treatment session is confidential and may only be released to another party by your written authorization.

RESPONSIBILITIES: As a client, you are required to arrive at your appointments on time, cancel or re-schedule appointments on the provision of 24 hours notice. If you are paying the insurance co-pay amount and are having the remaining portion of the fees paid by your insurance provider, the full amount must be discharged by you for a missed appointment, unless the requisite notice has been given. You will be charged 100% of the current session for no shows and late cancellations.

APPOINTMENTS: Every effort will be made to accommodate you at your preferred time for treatment. The shortest possible waiting time (if any) will be ensured.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

X_____Date_____/_____/_____

Signature of Patient, Parent or Guardian

REPRESENTATIVE _____