

**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 the document. Please ask any questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment.**

The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy. The doctor may use that procedure to treat you. The doctor may use his/her 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**

Be aware that if needed or necessary, the doctor may choose to do an examination of the primary complaint area and/or the whole body to correctly diagnose the condition. Also be aware the doctor may order radiographic studies including x rays.

**The material risks inherent in the 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 strains, 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 may feel some stiffness and soreness following the first few days of treatment. The doctor will make a very reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctors attention, it is your responsibility to inform the doctor.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor will 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 a million and one in five million adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options outside this office.**

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 pain-killers
- Hospitalization
- Surgeries

If you choose 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 with your primary care physician.

**The risks and dangers of attendant to 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.

**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 treatment/adjustment and related treatments. I have read the above and will present any questions that I have to the doctor concerning these treatments. 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 consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Doctors Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian  
(if minor)

# Total Health of Vero Beach New Patient Questionnaire

## Patient Information

### Please Print

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Seasonal Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # years \_\_\_\_\_  
Spouse or Parent Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone # \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_  
Name of Local Primary Physician \_\_\_\_\_ May we contact them? \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_  
Did you see our? Web Page? \_\_\_\_\_ Facebook? \_\_\_\_\_ Business Sign? \_\_\_\_\_ Word of mouth? \_\_\_\_\_

## Symptoms

Main complaint \_\_\_\_\_ When did it start \_\_\_\_\_  
How did it start \_\_\_\_\_

What activity bothers it most \_\_\_\_\_ Getting Better/Worse? \_\_\_\_\_  
When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working  
Rate the pain - (0 pain free – 10 unbearable pain) 0 1 2 3 4 5 6 7 8 9 10  
Secondary Complaint \_\_\_\_\_

Other chiropractors? \_\_\_\_\_ Positive experience? \_\_\_\_\_ Last Visit? \_\_\_\_\_  
Other type of physician or therapist? \_\_\_\_\_ Positive experience \_\_\_\_\_

## Health History – Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthmas	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Dx
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Kidney Dx	Liver Dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Chronic Fatigue	Hi Blood Pressure	Fibromyalgia	Other _____				

Women – How many children? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Date of Last Menstrual Cycle \_\_\_\_\_  
Nursing? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_

Previous surgeries and dates \_\_\_\_\_

List all medication your are currently taking \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

What supplement do you take? \_\_\_\_\_

How much do you smoke per day? \_\_\_\_\_ Drink per week? \_\_\_\_\_

\*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_