Coberly Chiropractic

PT ID #:_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a.) 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b.) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c.) There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a.) The condition that the treatment is to address;

b.) The nature of the treatment;

c.) The risks and benefits of that treatment; and

d.) Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation.

Date: _____

Patient (or Legal Guardian) Signature: _____

Print Name: _____

Print Name(of patient in cases of Legal Guardian):_____

Coberly Chiropractic

Patient Demographic Information

*Note: Please answer all questions and mark all applicable items.

Last Name: _____ First Name_____ M.I.: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Work #: _____ Cell #: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Age: _____ Number of children: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Email Address: _____ Health Insurance: _____

How did you hear of us? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Contact Person: _____ Relationship: _____

Contact #: _____ Employer: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

When: _____ Name of previous chiropractor: _____

What were you under care for? ☐ Cervicals ☐ Thoracics ☐ Lumbar ☐ Pelvis

☐ Other: _____

If other, please describe: _____

Were you happy with your previous care: ☐ Yes ☐ No

Name of Medical Doctor: _____ Phone #: _____

Patient Signature: _____ Date: _____

Coberly Chiropractic

Health Questionaire

*Note: Please answer all questions and mark all applicable items.

Reason(s) for visit: _____

_____

Is this visit attributed to an accident: ☐ Yes ☐ No

If answered yes, is it a(n): ☐ Auto ☐ Work ☐ Home ☐ Other

When did your symptoms appear: _____

_____

Getting worse? ☐ Yes ☐ No

How often do you have this problem? _____

Is the pain constant, intermittent, or get worse with activity? _____

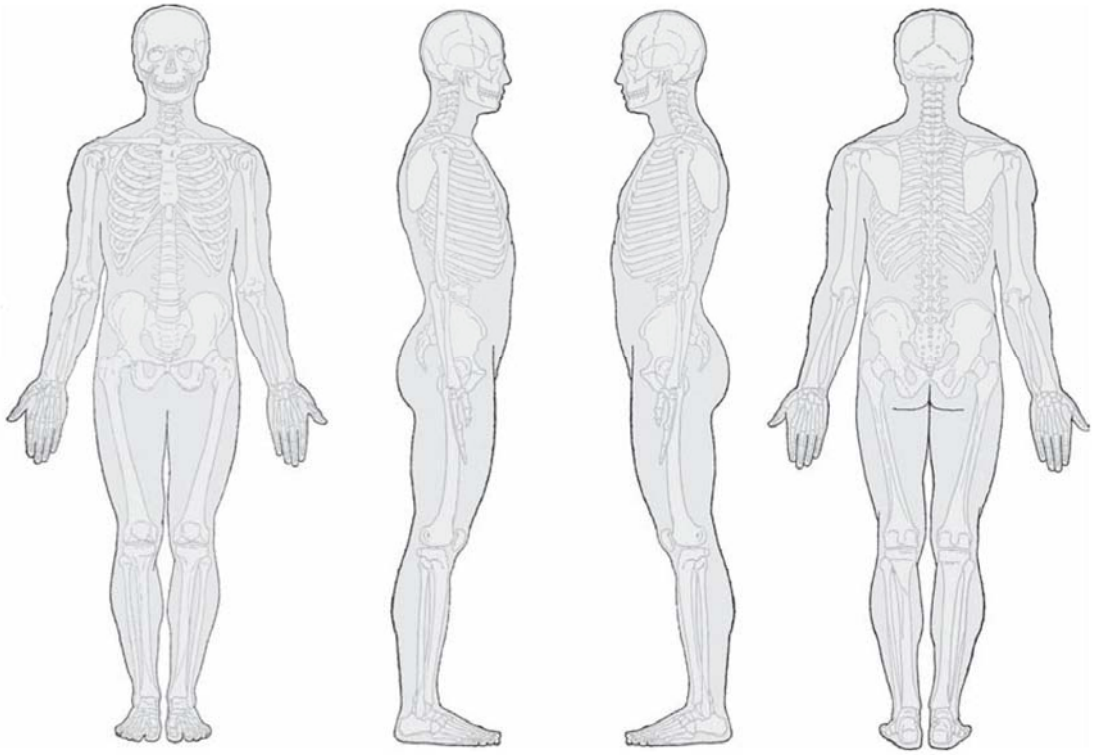
_____

Does it interfere w/: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are difficult/painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying ☐ Other: _____

Please mark you area(s) of pain on the figure below



Do you have any current diagnostic films/studies? ☐ Yes ☐ No

What treatment have you already received for this condition: _____

_____

Name doctors who have treated this condition: _____

What were the results: _____

_____

Please list:

ANY / ALL of the following with dosages, reason for taking them, and how long.

Medications: _____

_____

_____

Vitamins/Herbs/Minerals/Supplements: _____

_____

_____

Please list

ANY /ALL of the following (with dates and / or treatment when appropriate)

Injuries: _____

_____

Surgeries: _____

_____

Immunizations: _____

_____

Illnesses: _____

_____

Do you have an allergies: ☐ Yes ☐ No

If yes, allergies of what: _____