Medicare Intake Form/Contraindications

Patient Name _____ Date _____

Medicare requires us to inform you of both the relative and absolute contraindications to receiving a chiropractic adjustment. We ask that you read through these and let us know if any of them apply to you.
Please write Yes or No to the following.

Relative Contraindications

Joint Instability ☐ Yes ☐ No
If yes, which joint(s)? _____

Severe Osteoporosis ☐ Yes ☐ No

Spinal Tumors ☐ Yes ☐ No

Bleeding Disorder ☐ Yes ☐ No

Anticoagulant Therapy ☐ Yes ☐ No

Nerve Root Impingement ☐ Yes ☐ No
If yes, do you have any pain in your extremities? _____
If yes, which extremity? _____

Absolute Contraindications

Swollen Red Joints With Ligament Laxity ☐ Yes ☐ No
If yes, which joints? _____

Any Known Fractures or Dislocations ☐ Yes ☐ No

Any Known Healed Fractures or Dislocations That Have Not Healed Properly or Are Currently Causing You Pain

_____

Medicare Intake Form/Contraindictions (cont.)

Patient Name _____ Date _____

Malignancies ☐ Yes ☐ No
If yes, where? _____

Infections of the Spine ☐ Yes ☐ No

Cauda Equina Syndrome ☐ Yes ☐ No

Any aneurysms? ☐ Yes ☐ No
If yes, where? _____

Any past history of stroke? ☐ Yes ☐ No

Any past history of ischemic attacks? ☐ Yes ☐ No

Any past history of dizziness,
combined facial numbness or weakness? ☐ Yes ☐ No
If yes, did you seek medical attention? _____

Patient Signature _____ *Date* _____