

Pfeffer Chiropractic & Concussion Clinic

Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member. Thank you!

Patient Information

First Name: _____ Middle: _____ Last: _____ Gender: M F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security # _____

Email Address: _____ Birthdate: _____

Marital Status: S M W D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____ Social Security # _____

Children Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____

Name of Employer: _____

Employer phone number: _____ City: _____

Person responsible for this Account: _____

Additional Information

How did you hear about us? _____

In case of emergency, whom should we contact? _____

Relation to Patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates of your progress? Yes No

What is your primary complaint? _____

Is this Worker's Compensation? _____ Is this personal Injury? _____

Office Use Only: Date: _____ Entered: _____

NAME: _____ DATE: ____ / ____ / ____ Account#: _____

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

TIMING & DURATION

How often do you experience this pain? _____ Constant _____ Frequent _____ Intermittent _____ Occasional

What caused the onset? _____

Date of onset? ____ / ____ / ____ (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None	1 = Minimal	2 = Very Mild	3 = Mild	4 = Mild to Moderate	5 = Moderate
6 = Moderate to Severe	7 = Mildly Severe, Restricts Some Activity	8 = Severe, Limits Most Activity	9 = Very Severe	10 = Excruciating	

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
 _____ 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

What is the least intense the symptom has been on a scale of 0 to 10?
 _____ 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

What is the most intense the symptom has been on a scale of 0 to 10?
 _____ 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply → _____ Inflexibility _____ Stiffness _____ Spasms _____ Cramps

If this pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

- | | | | | | |
|---------------|----------------|---------------------|----------------------|----------------|----------------|
| _____ Sharp | _____ Stabbing | _____ Aching | _____ Pins & Needles | _____ Pounding | _____ Shooting |
| _____ Burning | _____ Dull | _____ Tingling/Numb | _____ Throbbing | _____ Crawling | _____ Stinging |

MODIFYING FACTORS

What aggravates the pain/symptom?

- | | | | | |
|---------------------------|----------------|--------------------------|-------------------------|-----------------------------|
| _____ Sneezing | _____ Lifting | _____ Exercising | _____ Looking up/down | _____ Walking |
| _____ Coughing | _____ Sitting | _____ Stooping | _____ Looking side/side | _____ Standing |
| _____ Stress | _____ Driving | _____ Getting out of bed | _____ Pushing | _____ Pulling |
| _____ Repetitive movement | _____ Carrying | _____ Straining at BM | _____ Climbing stairs | _____ Getting in/out of car |

Other: _____

What relieves this pain/symptom?

- | | | | | |
|---------------|----------------|----------------|-------------------------|-----------------------|
| _____ Resting | _____ Sleeping | _____ Lifting | _____ Exercising | _____ Looking up/down |
| _____ Shower | _____ Advil | _____ Stooping | _____ Looking side/side | _____ Mineral Ice |
- Other: _____

Over the past weeks/months this complaint is: _____ Improving _____ Getting worse _____ About the same

Have you seen anyone for this condition? _____ YES _____ NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the least intense the symptom has been on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the most intense the symptom has been on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply → ___ Inflexibility ___ Stiffness ___ Spasms ___ Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

___ Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting
___ Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging

Over the past weeks/months this complaint is: ___ Improving ___ Getting worse ___ About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the least intense the symptom has been on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the most intense the symptom has been on a scale of 0 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply → ___ Inflexibility ___ Stiffness ___ Spasms ___ Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

___ Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting
___ Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging

Over the past weeks/months this complaint is: ___ Improving ___ Getting worse ___ About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

2. What do you enjoy doing most in your life?

NOTES / COMMENTS:

Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:

Please place a checkmark by the condition that applies to you: P = Present • N = Not Present • PP = If it has ever been present in the past

P	N	PP		P	N	PP		P	N	PP		P	N	PP	
			Fatigue				Irritability				Joint Stiffness				Seizures
			Fever				Depression				Spinal Curvature				Dizziness
			Chills				Memory Loss				Back Pain				Tremors
			Night Sweats				Headache				Hot Joints				Loss of Sensation
			Fainting				Muscle Pain				Joint Swelling				Loss of Coordination
			Nervousness				Muscle Weakness				Stiff Neck				Paralysis
			Concentration Loss				Muscle Cramps				Lumps / Masses				Difficulty of Speech

P = Present • N = Not Present • PP = If it has ever been present in the past • Do the same for your family

Family History Key: F = Father • M = Mother • B = Brother • S = Sister • GF = Grandfather • GM = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? ____YES ____NO

Are you Pregnant? ____YES ____NO

Do you think you may be pregnant? ____YES ____NO

FOR DOCTOR'S USE ONLY - PATIENT PLEASE PROCEED TO PAGE 5

REVIEW OF SYSTEMS

SYSTEM REVIEWED

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergic / Immunologic | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hematological / Lymphatic |
| <input type="checkbox"/> Constitutional | <input type="checkbox"/> Integumentary | <input type="checkbox"/> Ears / Nose / Mouth | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Neurological | <input type="checkbox"/> Eyes | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Respiratory | <input type="checkbox"/> All other system reviews negative | |

Notes / Comments: _____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ DATE: ____ / ____ / ____ Account#: _____

PLEASE LIST PAST SURGERIES:

1. _____ Year _____ 2. _____ Year _____
 3. _____ Year _____ 4. _____ Year _____
 5. _____ Year _____ 6. _____ Year _____

What other major injuries have you had? Date	Have you ever taken:	YES	NO	YEAR
	Insulin			
	Cortisone			
	Thyroid Medicine			
	Male/Female Hormones			
What medications are you currently taking? Date	Blood Pressure			
	Tranquilizers/Sedatives			
	Birth Control			
Hospitalizations:				

Marital Status: Married Divorced Single Separated Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: Never Rarely Occasionally Moderately Regularly

Intensity of Exercise: Low Level Medium Level High Level Competition Level

Sufficient Rest: Never Rarely Occasionally Moderately

Hours of Sleep: 6 8 10 More than 10

Well balanced diet: Never Rarely Occasionally Moderately

Do you smoke? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 packs/day

Do you drink caffeinated beverages? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 drinks/day

Do you drink alcoholic beverages? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 drinks/day

Have you ever used street drugs? Yes No

Hobbies: _____

Patient history was obtained from: Patient Father Mother Son Daughter

Notes / Comments: _____

Doctor Signature: _____

Patient Signature: _____

Date: _____

First Name: _____ Last Name: _____ Initial _____

Revised Oswestry Low Back Pain Disability Questionnaire

Please rate the severity of your pain by circling a number: *No pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem

Section 1 – Pain Intensity

- 0. The pain comes and goes and is very mild.
- 1. The pain is mild and does not vary much.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain comes and goes and is severe.
- 5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- 0. I would not have to change my way of washing or dressing in order to avoid pain.
- 1. I do not normally change my way of washing or dressing even though it causes some pain.
- 2. Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3. Washing and dressing increase the pain and I find it necessary to change my way of doing it. three-quarters.
- 4. Because of the pain I am unable to do some washing and dressing without help.
- 5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it gives extra pain.
- 2. Pain prevents me lifting heavy weights off the floor.
- 3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- 4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 5. I can only lift very light weights at most.

Section 4 – Walking

- 0. I have no pain on walking.
- 1. I have some pain walking but it does not increase with distance.
- 2. I cannot walk more than 1 mile without increasing pain.
- 3. I cannot walk more than 1/2 mile without increasing pain.
- 4. I cannot walk more than 1/4 mile without increasing pain.
- 5. I cannot walk at all without increasing pain.

Section 5 – Sitting

- 0. I can sit in any chair as long as I like.
- 1. I can sit only in my favorite chair as long as I like.
- 2. Pain prevents me from sitting more than 1 hour.
- 3. Pain prevents me from sitting more than 1/2 hour.
- 4. Pain prevents me from sitting more than 10 minutes.
- 5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

- 0. I can stand for as long as I want without pain.
- 1. I have some pain on standing but it does not increase with time.
- 2. I cannot stand for longer than 1 hour without increasing pain.
- 3. I cannot stand for longer than 1/2 hour without increasing pain.
- 4. I cannot stand for longer than 10 minutes without increasing pain.
- 5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

- 0. I get no pain in bed.
- 1. I get pain in bed but it does not prevent me from sleeping well.
- 2. Because of pain my normal nights sleep is reduced by less than one-quarter.
- 3. Because of pain my normal nights sleep is reduced by less than one-half.
- 4. Because of pain my normal nights sleep is reduced by less than three-quarters.
- 5. Pain prevents me from sleeping at all.

Section 8 – Social Life

- 0. My social life is normal and gives me no pain.
- 1. My social life is normal but it increases the degree of pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- 3. Pain has restricted my social life and I do not go out very often.
- 4. Pain has restricted my social life to my home.
- 5. I have hardly any social life because of the pain.

Section 9 – Traveling

- 0. I get no pain when traveling
- 1. I get some pain when traveling but none of my usual forms of travel make it any worse.
- 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- 3. I get extra pain while traveling which compels to seek alternative forms of travel.
- 4. Pain restricts me to short necessary journeys under 1/2 hour.
- 5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

- 0. My pain is rapidly getting better.
- 1. My pain fluctuates but is definitely getting better.
- 2. My pain seems to be getting better but improvement is slow.
- 3. My pain is neither getting better or worse.
- 4. My pain is gradually worsening.
- 5. My pain is rapidly worsening.

Total _____

Instructions: 1. To determine the patient's index, add up the total points from all sections and divide this total by 50 (total possible points). Multiply that number by 100. 2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Patient's Signature: _____ Date: _____

Pfeffer Chiropractic & Concussion Clinic

First Name: _____ Last Name: _____ Initial: _____ Date: _____

The Neck Disability Index

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and circle the number that most applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

0. I can look after myself normally, without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but I manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4-READING

0. I can read as much as I want to, with no pain in my neck.
1. I can read as much as I want to, with slight pain in my neck.
2. I can read as much as I want to, with moderate pain in my neck.
3. I can't read as much as I want, because of moderate pain in my neck.
4. I can hardly read at all, because of severe pain in my neck.
5. I cannot read at all.

SECTION 5-HEADACHES

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

SECTION 6-CONCENTRATION

0. I can concentrate fully when I want to, with no difficulty.
1. I can concentrate fully when I want to, with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

SECTION 7-WORK

0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

SECTION 8-DRIVING

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want, with slight pain in my neck.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't drive my car as long as I want, because of moderate pain in my neck.
4. I can hardly drive at all, because of severe pain in my neck.
5. I can't drive my car at all.

SECTION 9-SLEEPING

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

0. I am able to engage in all my recreation activities, with no neck pain at all.
1. I am able to engage in all my recreation activities, with some neck pain.
2. I am able to engage in most. But not all, of my usual recreation activities, because of pain in my neck.
3. I am able to engage in few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. I can't do any recreation activities at all.

Patient's Signature: _____ Date: _____

Pfeffer Chiropractic
& Concussion Clinic

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Pfeffer Chiropractic & Concussion Clinic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Pfeffer Chiropractic & Concussion Clinic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

Date

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices. The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

Printed Name – Patient or Representative

Signature

Date

Relationship to Patient
(if other than patient)

Witness:

Printed Name – Clinic Representative

Signature

Date

For Internal Use:

Patient Refused to Sign Patient unable to sign for the following reason: _____

Pfeffer Chiropractic & Concussion Clinic

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____