

# Informed Consent for Chiropractic Treatment and Acupuncture

Chiropractors, physiotherapists, and medical doctors are required to advise their patients of material risks associated with treatment of their specific condition.

## In regards to Chiropractic Joint Manipulation:

- Spinal adjustments, on rare occasions, may result in ligament sprains; muscle strains; or rib fractures.
- Injury to the Vertebral Artery has occurred during cervical manipulation. This may result in neurological impairment or stroke. Scientific evidence estimates the risk to be 1 case in 450,000 - 1.4 million neck manipulations. We do not currently possess the ability to accurately predict which patients are at risk for this event.

## In regards to Acupuncture:

- Acupuncture is generally very safe. Serious side-effects are very rare – less than one per 10,000 treatments.
- Drowsiness occurs after treatment in a small number of patients. In rare instances, fainting can occur in certain patients, particularly on the first treatment.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment is normal and typically occurs in about 1% of treatments. A worsening of symptoms is normal and is usually a sign of a good treatment.
- **SINGLE-USE, STERILE, DISPOSABLE NEEDLES ARE USED IN THIS CLINIC.**

## Please notify your doctor:

- If you have had past surgical intervention to a joint, or the spine.
- If you are prone to fainting.
- If you have a pacemaker or other electrical implants.
- If you have a bleeding disorder, are currently taking anti-coagulants, or have high blood pressure.

I have been fully informed of my specific diagnosis and I have discussed the proposed treatment plan in detail. I am aware of the risks inherent to my treatment and realize that my condition may improve, deteriorate, or sustain its current status.

I do hereby give my consent to be treated willingly and voluntarily. I recognize that my consent is specific to my current complaint and the treatment plan that has been proposed. I am aware that I may withdraw my consent to treatment, in whole or in part, on any occasion.

## **Dated:**

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Patient Name (print please)

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Patient Signature

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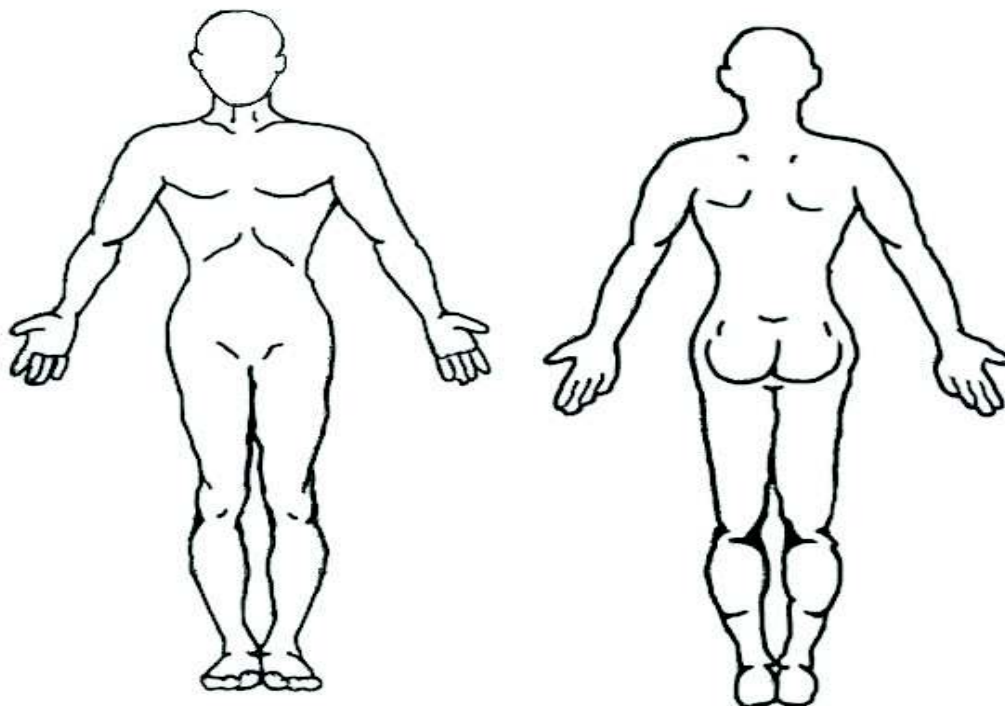
Witness Name

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Witness Signature



In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensations(s) you are **currently** experiencing. Please include all areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.



**Symbols:**

**Numbness**    // // // //  
                   // // // //

**Stabbing or Sharp**    || || || ||  
                               || || || ||

**Dull Ache**    + + + +  
                   + + + +

**Burning**    x x x x  
                   x x x x

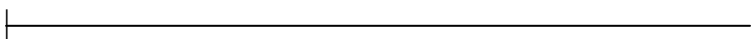
**Stiff & Tight**    = = = =  
                       = = = =

**Pins & Needles**    • • • •  
                           • • • •

*How severe is your pain today? Please place a vertical mark along the line below to indicate how bad you feel your pain is today.*

No Pain

Worst Pain Imaginable



0

100

*Do you have any of the following?*

- Jaw Pain
- Shoulder Pain
- Elbow Pain
- Wrist Pain
- Back Pain
- Hip Pain
- Knee Pain
- Foot Pain
- Muscle Pain

- Asthma
- Allergies
- Constipation
- Painful Menstruation
- Dizziness
- Fatigue/Weakness
- Problems Sleeping
- Back Ache
- Headache
- Stiff Neck

- Arthritis
  - Rheumatoid Arthritis
  - Prescription Medication
- Please List: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



# Motor Vehicle Crash Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of injury/accident: \_\_\_\_\_

Time of injury: \_\_\_\_\_  AM  PM

City where crash occurred: \_\_\_\_\_

Was the street wet or dry?  Wet  Dry

Location where crash occurred: \_\_\_\_\_

Who owns the vehicle in which you were hit? \_\_\_\_\_

What is the estimated repair damage to your vehicle? \$ \_\_\_\_\_

Who made damage estimates on your vehicle? \_\_\_\_\_

Yes  No Did the police come to the accident scene?

Yes  No Did the police make a written report?

Yes  No Were any traffic citations written for either of the involved parties?  
If yes whom and for what: \_\_\_\_\_

Yes  No Were any photographs taken of the vehicle?

## DESCRIBE HOW THE CRASH HAPPENED

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## COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

Single car crash  Two-vehicle crash  Three or more vehicles

Rear-end crash  Side crash  Rollover

Head-on crash  Hit guard rail, tree, object  Ran off the road

Other (Describe): \_\_\_\_\_

What was your seating position in the vehicle at the time of the crash? \_\_\_\_\_

## DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown)

Model, make, year: \_\_\_\_\_  Unknown

## DESCRIBE THE OTHER VEHICLE (If not certain, check unknown)

Model, make, year: \_\_\_\_\_  Unknown

## AT THE TIME OF THE IMPACT YOUR VEHICLE WAS:

Slowing down  Moving at a constant speed  Changing lanes

Stopped  Making a turn  Making a U turn

Gaining speed  Proceeding straight ahead  Other: \_\_\_\_\_

**AT THE TIME OF THE IMPACT THE OTHER VEHICLE WAS:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Slowing down  | <input type="checkbox"/> Moving at a constant speed | <input type="checkbox"/> Changing lanes  |
| <input type="checkbox"/> Stopped       | <input type="checkbox"/> Making a turn              | <input type="checkbox"/> Making a U turn |
| <input type="checkbox"/> Gaining speed | <input type="checkbox"/> Proceeding straight ahead  | <input type="checkbox"/> Other: _____    |

**AFTER THE CRASH, CHECK IF YOUR VEHICLE DID THE FOLLOWING:**

- |  |   |
|--|---|
| <input type="checkbox"/> Kept going straight, not hitting anything       | <input type="checkbox"/> Spun around, not hitting anything    |
| <input type="checkbox"/> Kept going straight, hitting a vehicle in front | <input type="checkbox"/> Spun around, hitting another vehicle |
| <input type="checkbox"/> Was hit by another vehicle                      | <input type="checkbox"/> Hit curb or other object             |

**INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:** (Please draw lines from the body regions on the left side and match to the right side.)

**BODY REGION**

- Head
- Face
- Shoulder
- Arm/hand
- Front chest wall
- Side chest wall
- Hip/abdomen
- Knee
- Leg
- Foot

**OBJECT YOU HAD CONTACT WITH**

- Windshield or side window
- Steering wheel
- Side of door
- Dashboard
- Knee bolster/glove compartment
- Seatbelt (Lap belt or shoulder harness)
- Frame of car near windows
- Roof or top part of vehicle
- Another occupant/animal
- Other: \_\_\_\_\_

**CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Windshield     | <input type="checkbox"/> Seat frame       | <input type="checkbox"/> Knee bolster |
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Side-rear window | <input type="checkbox"/> Side door    |
| <input type="checkbox"/> Dash           | <input type="checkbox"/> Mirror           | <input type="checkbox"/> Other: _____ |

**ALL TYPES OF COLLISIONS (Indicate those relevant to your case.)**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body slide under the seatbelt?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the door(s) of your vehicle damaged to the point where you could not open the door?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did an airbag deploy in your vehicle during the crash? If yes circle: (Side airbag / Front airbag)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the frame of your vehicle bent or damaged?  |

**SEATBELT USAGE AND HAND PLACEMENT:**

YES NO

- Were you wearing a seatbelt?
- If yes, does your seatbelt have a:  Lap and shoulder strap,  
 Lap belt only
- Did you have any portion of your seatbelt placed behind your chest, back or shoulder
- Were you holding onto the steering wheel at the time of impact? (Driver only)

*If yes, indicate where each hand was positioned (Use time clock face as your reference)*

**Left hand:**  Not on wheel  Yes, hand at \_\_\_\_\_ o'clock,  Hand elsewhere

**Right hand:**  Not on wheel  Yes, hand at \_\_\_\_\_ o'clock,  Hand elsewhere

**REAR-END COLLISIONS ONLY (Answer this section only if you were hit from the rear.)**

**Describe your vehicle's head restraint system:**

- Moveable/adjustable head restraint  Fixed, non-moveable head restraint
- No headrests in my vehicle  Bench seat in your vehicle without restraint

**Please indicate how your head restraint was positioned at the time of the crash (if present)**

- At the top of the back of your head  Midway height of the back of your head
- Lower height of the back of the head  Located at the level of your neck
- Level of your shoulder blades

**BRUISING AFTER THE CRASH**

YES NO

- Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash?  
If yes, indicate where bruising was located on your body and what caused the bruising:

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**AWARENESS AND BODY POSITION DESCRIPTIONS:** *Check all areas that apply to you.*

- You were unaware of the impending collision. You did not see or hear brakes prior to impact.
- You were unaware of the impending crash and relaxed before the collision.
- You were unaware of the impending crash and braced yourself.
- Your body, torso, and head were facing straight ahead.
- You had your head and/or torso turned at the time of the collision:
  - Turned left  Turned right

**Describe how far you were turned/twisted and why you were turned/what were you doing:**

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- You were leaning forward prior to the collision resulting in a gap between your back and the seatback.  
**If yes, indicate how far you were leaning and why you were leaning forward:**

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- Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU FIRST NOTICE ANY STIFFNESS, SORENESS, OR PAIN AFTER THE CRASH? (Indicate if immediate or if it started in hours/days):

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## Post-trauma Symptoms Questionnaire

**PATIENT INSTRUCTIONS:** *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single mark or several check marks in the appropriate columns for the specific symptom that applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank of the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HRS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS RECENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/Migraine				
Dizziness				
Tinnitus (Ringing in the ears)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sleep disturbance				
Fatigue				
Anxiety				
Painful or difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Upper arm burning pain				
Arm pain/tingling/numbness				
Wrist/hand/finger/pain/numbness				
Hand or grip weakness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Ribcage pain/soreness				
Breast pain and/or bruising				
Low back pain/soreness/aching				
Hip pain				
Shooting pain down the entire leg				
Pain radiating down upper leg				
Leg numbness/tingling				
Knee Pain				
Ankle/foot pain				
Other:				

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

## Pain Disability Questionnaire Please Fax to

Print with capital letters within the boxes

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

Shade bubbles like this → ●

**PLEASE** darken the circle next to **THE ONE CHOICE** which most closely describes your **CURRENT** condition.

1. Does your pain interfere with your normal work inside and outside the home?
 

Work normally	Unable to work at all									
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
 

Take care of self completely	Need help with all personal care								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your pain interfere with your traveling?
 

Travel anywhere I like	Only travel to see doctors								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your pain affect your ability to sit or stand?
 

No problems	Can not sit/stand at all								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
 

No problems	Can not do at all								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
 

No problems	Can not do at all								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Does your pain affect your ability to walk or run?
 

No problems	Can not walk/run at all								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Has your income declined since your pain began?
 

No decline	Lost all income								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Do you have to take pain medication every day to control your pain?
 

No medication needed	On pain medication throughout day								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Does your pain force you to see doctors much more often than before your pain began?
 

Never see doctors	See doctors weekly								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
 

No problems	Never see them								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Does your pain interfere with recreational activities and hobbies that are important to you?
 

No interference	Total interference								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
 

Never need help	Need help all the time								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Do you now feel more depressed, tense, or anxious than before your pain began?
 

No depression/tension	Severe depression/tension								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
 

No problems	Severe problems									
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
0	1	2	3	4	5	6	7	8	9	10

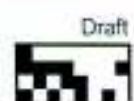
F Name Initial  L Name Initial  Last 4 digits of SSN

This questionnaire is designed to enable the doctor to understand how much your neck and/or back pain has affected your ability to manage your everyday activities.

Staff use only				
	<b>DC</b>			Discharge
Doctor Name	Doctor ID	Designation	60 <input type="radio"/>	90 <input type="radio"/>
			150 <input type="radio"/>	<input type="radio"/>

/  /

Date



Examiner Signature

Case # \_\_\_\_\_

# CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

**An understanding of your health history will help us to determine appropriate care.**

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ RACE \_\_\_\_\_ GENDER \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

### Review of Systems

1. Do you have skin, hair or nail problems?     Yes     No \_\_\_\_\_
2. Do you have mouth and/or throat problems?     Yes     No \_\_\_\_\_
3. Do you have nose and/or sinus problems?     Yes     No \_\_\_\_\_
4. Do you have ear problems?     Yes     No \_\_\_\_\_
5. Do you have eye problems?     Yes     No \_\_\_\_\_
6. Do you have chest or lung (breathing) problems?     Yes     No \_\_\_\_\_
7. Do you smoke?     Yes     No    Amount per day \_\_\_\_\_ How Long? \_\_\_\_\_
8. Do you have heart and/or blood vessel problems?     Yes     No \_\_\_\_\_
9. Do you have blood or lymph node problems?     Yes     No \_\_\_\_\_
10. Do you have digestive problems?     Yes     No \_\_\_\_\_
11. Do you have genital problems (e.g. prostate, testicular, vaginal)?     Yes     No \_\_\_\_\_
12. Do you have urinary (including kidney or bladder) problems?     Yes     No \_\_\_\_\_
13. **Females**, have you had menstrual problems?     Yes     No \_\_\_\_\_  
 Have you ever taken birth control pills?     Yes     No    For how long? \_\_\_\_\_  
 Is there any chance that you are currently pregnant?     Yes     No  
 Do you have any breast problems?     Yes     No \_\_\_\_\_
14. Do you have any nervous system diseases and/or mental health problems?     Yes     No \_\_\_\_\_
15. Do you have any gland and/or hormone problems?     Yes     No \_\_\_\_\_
16. Do you have allergy or immunity problems?     Yes     No \_\_\_\_\_
17. Do you have any muscle, tendon or ligament problems?     Yes     No \_\_\_\_\_
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)?     Yes     No \_\_\_\_\_

### Past History

19. List any diseases which you have had in the past, including childhood diseases: \_\_\_\_\_  
 \_\_\_\_\_
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: \_\_\_\_\_  
 \_\_\_\_\_
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?     Yes     No  
 \_\_\_\_\_  
 \_\_\_\_\_
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

(OVER PLEASE)

Case # \_\_\_\_\_

## CASE HISTORY (CONTINUED)

FULL NAME \_\_\_\_\_

DATE \_\_\_\_\_

23. Have you ever been hospitalized for any reason other than surgery?  Yes  No \_\_\_\_\_

24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_  
\_\_\_\_\_

25. Your diet is:  Balanced  Fair  Poor  Excessive  Restricted

### Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?  Yes  No \_\_\_\_\_

### Social History

27. In what position do you usually sleep, and how well? \_\_\_\_\_  
\_\_\_\_\_

28. Do you exercise on a regular basis?  Yes  No How? \_\_\_\_\_

29. How do you spend your spare time (hobbies, etc)? \_\_\_\_\_

30. Do you use:  Caffeine?  Tobacco?  Nicotine?  Recreational Drugs?  Alcohol?

31. Please describe your work.

Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker

Physical Demands:  Heavy  Moderate  Mild  Sedentary

Stress Level:  High  Medium  Low

### Additional Questions

32. Do you have problems with recurring headaches?  Yes  No \_\_\_\_\_

33. Are you losing weight without trying?  Yes  No

34. Does your pain wake you up at night?  Yes  No

35. Have you had a change in bowel or bladder habits?  Yes  No \_\_\_\_\_

36. Have you had a sore that doesn't heal?  Yes  No \_\_\_\_\_

37. Have you recently had any unusual bleeding or discharge?  Yes  No \_\_\_\_\_

38. Do you have a thickening/lump in the breast or elsewhere?  Yes  No \_\_\_\_\_

39. Do you have indigestion or difficulty swallowing?  Yes  No \_\_\_\_\_

40. Have you had an obvious change in a wart or mole?  Yes  No \_\_\_\_\_

41. Do you have a nagging cough or hoarseness?  Yes  No \_\_\_\_\_

42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.  
\_\_\_\_\_  
\_\_\_\_\_

43. Please describe your current complaint. In other words, what brought you here? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

44. Who is your:

Medical Doctor? \_\_\_\_\_

OB/GYN? \_\_\_\_\_

Dentist? \_\_\_\_\_

Case # \_\_\_\_\_

# PATIENT HEALTH SURVEY

FULL NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

**Have you ever (at any time) experienced any of the following?**

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

**Have you ever been diagnosed with or told you have one of the following?**

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

**Do you currently have, or could you be, any of the following?**

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
<input type="checkbox"/> Male <input type="checkbox"/> Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs.day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

**In the past 14 days (2 weeks), have you experienced any of the following?**

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

***Pregnancy Release: Informed Consent to X-ray***

All women of childbearing age must sign this release and check any appropriate categories.

This is to certify that to the best of my knowledge I am NOT pregnant and that Conrad Chiropractic & Wellness LLC has my permission to take x-rays. I furthermore assume all responsibilities in the event that I am currently pregnant.

- Tubal Ligation
- Birth Control Pill
- Intra-Uterine Device
- First 10 days of menstrual cycle    Date: \_\_\_\_\_
- Menopause or post-menopause
- Same gender partner
- Not sexually active
- Other contraceptive method : \_\_\_\_\_

Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

***Parent/Guardian Consent for Examination and X-ray***

I, the undersigned, as a parent or guardian with no limited access, give my consent for \_\_\_\_\_ to be examined and x-rayed if necessary at Conrad Chiropractic & Wellness LLC.

Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature