

# 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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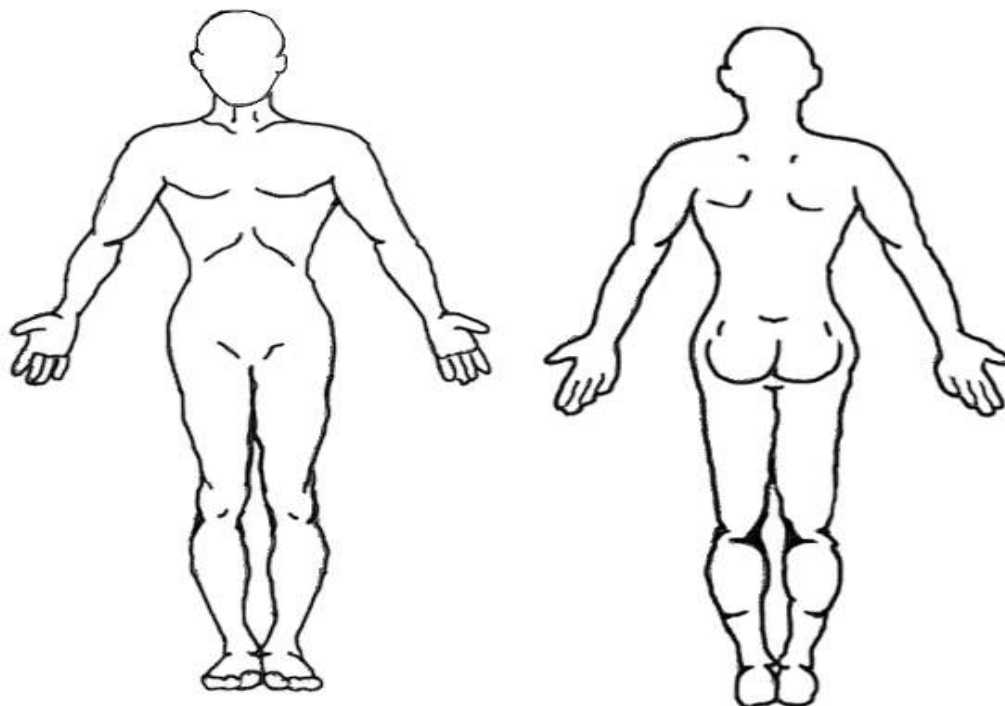
Witness Name

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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**    xxxx  
                   xxxx

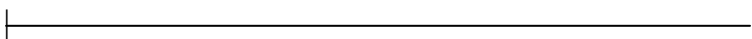
**Stiff & Tight**    =====  
                               =====

**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: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## QUADRUPLE VISUAL ANALOGUE SCALE

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

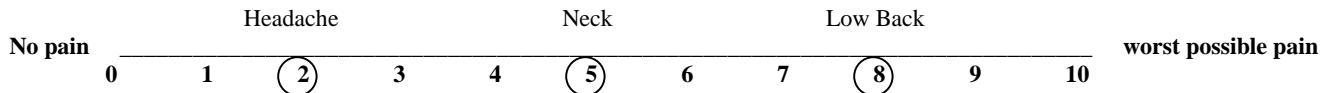
Date \_\_\_\_\_

**Please read carefully:**

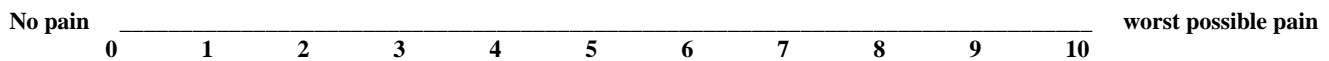
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

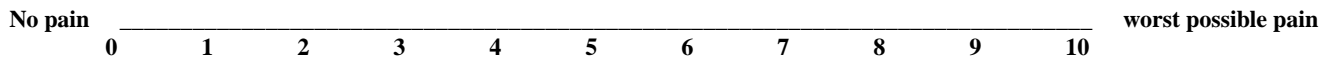
**Example:**



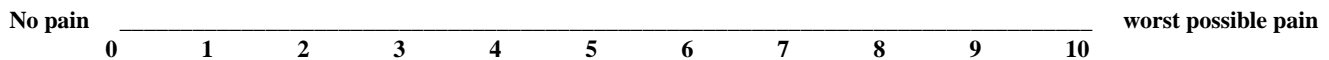
**1 – What is your pain RIGHT NOW?**



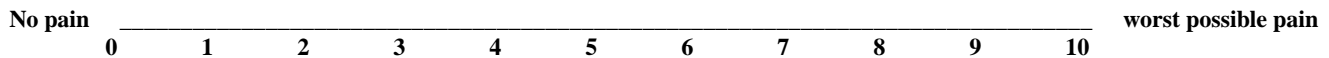
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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