Ross Valley Chiropractic
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Patient Informed Consent Form

Patient Name:_____
To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: **Please initial here to consent to these treatments_____**
(Circle any treatments you do not consent to)

Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological evaluation, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, electro muscular stimulation, Super Pulsed Laser Stim Therapy, radiographic studies, Kineseo tape, application of herbal medicinal patch, topical pain-relieving ointments, orthopedic supports and heel lifts, Orthopedic plaster cast
___ Other (please explain)
_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination

and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Christine A. Dillon, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____	_____
Patient's Name (*Print)*	**Doctor's Name**
_____	_____
Patient's Signature	**Doctor's Signature**

_____
Signature of Parent or Guardian
(if a minor)

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Patient Introduction

Name_____ Today's Date_____
Address_____
City,State,Zip_____ Date of Birth_____
Cell Phone_____ Height_____Weight____
Home Phone_____ Married____Single_____
Work Phone_____ Life Partner_____
Email:_____
Occupation_____ Children_____
Employed by_____
Referred by_____
If minor, parent name and contact info:
_____
_____
Emergency contact:
_____
Relationship to contact:
_____

Previous Chiropractic care_____
Where?_____

Primary Care Provider: _____

If you have insurance that covers Chiropractic care and you would like a Superbill to submit to them yourself, please check here:_____

Inform us if you have Medicare. We can bill MC for you.
Payment is due to us at the time of service and your insurance will reimburse you directly.

Please note: You are personally responsible for payment of your fees. Fees are payable when service is rendered unless special arrangements are made. Insurance is considered a method of reimbursing the patient for fees paid 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 company. There is no fee for missed appointments if the office is notified 24 hours prior to the scheduled appointment.

In case of insurance billing: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician for services.

Patient's signature_____

Chief Complaints or Problems

Location_____
_____
_____
When did it start?_____
How frequent?_____
What aggravates it?_____
_____
What relieves it?_____
_____
Describe pain:___dull ___sharp ___burning___ aching ___deep ___superficial___ other_____
Does the pain travel? Where?_____
_____
Previous occurrences_____
_____
Any other issues you wish to discuss or work on_____
_____
_____
_____
_____
Medications: Kind and dosage_____
_____
_____
Supplements and vitamins:_____
_____
_____
_____
_____

Personal Health History

Do you have, or suspect you have any allergies?_____
_____
Drug allergies?_____
_____
Injuries: Please list with location & date:
Broken bones_____
Sprains/strains_____
Dislocations_____
Falls_____
Concussion/head injury_____
Auto accidents_____
Other accidents or injuries_____
_____
_____

Surgery

List surgeries and dates_____
_____
_____

Blood Chemistry

Date of most recent blood tests____
_____
Most recent X-ray, MRI, CT scan___
_____

Has any blood relative ever had:

	Yes	**No**
Arthritis	____	____
Allergies	____	____
Cancer	____	____
Chronic back pain	____	____
Chronic neck pain	____	____
Diabetes	____	____
Heart trouble	____	____
Stroke	____	____
Mental illness	____	____
Auto Immune Disease	____	____

Physical Symptoms

*Circle **1** if current problem
*Circle **2** if past or recurring problem

Musculo-Skeletal System/Nervous System

1 **2** Low back pain or stiffness
1 **2** Pain between shoulders
1 **2** Neck pain or stiffness
1 **2** Pain in arm or shoulder
1 **2** Tingling or loss of feeling in arm, shoulder or hand
1 **2** Weakness of arm, shoulder or hands
1 **2** Muscle spasms
1 **2** Leg pain
1 **2** Tingling or loss of feeling in leg or foot

Physical Symptoms

*Circle **1** if current problem
*Circle **2** if past or recurring problem

Musculo-Skeletal System/Nervous System

1 2 Weakness in leg or foot
1 2 Knee problems
1 2 Foot problems
1 2 Swollen, painful or stiff joints
1 2 Walking problems
1 2 Leg cramps when walking, or at night
1 2 Numbness
1 2 Dizziness
1 2 Fainting
1 2 Seizures
1 2 Balance Trouble
1 2 Headaches~ Describe type & Frequency_____
1 2 Muscle jerking
1 2 Tremor
1 2 Strange taste or loss of taste
1 2 Difficulty swallowing

Gastro-Intestinal System

1 2 Poor appetite
1 2 Excessive hunger
1 2 Stomach or abdominal pain after meals
1 2 Belching or heartburn
1 2 Nausea or vomiting
1 2 Intestinal gas
1 2 Diarrhea
1 2 Constipation
1 2 Bowel movements: How often _____
1 2 Change in size, shape or texture of BM?
1 2 Hemorrhoids
1 2 Gall bladder problem
1 2 Discomfort related to food
1 2 Gluten sensitivity
1 2 Dairy sensitivity
1 2 Sugar sensitivity

General Health

1 2 Weight loss or gain +/- 10 lbs In last year
1 2 Loss of energy
1 2 Depression
1 2 Loss of sleep
1 2 Insomnia
1 2 Loss of memory
1 2 Crying spells
1 2 Frequent colds or sore throat
1 2 Tiredness with no apparent reason
1 2 Low grade or persistent fever
1 2 Always cold
1 2 Bruise easily
1 2 Periods of anxiety
1 2 Periods of rage or anger

Ear, Nose, Throat & Skin

1 2 Do you wear glasses? When last checked_____
1 2 Other eye or vision problems If so, what_____
1 2 Ear pain
1 2 Ear feels “stopped up”
1 2 Ringing or buzzing in ear
1 2 Ear discharge
1 2 Hearing loss
1 2 Nose pain
1 2 Nose bleeding
1 2 Nose discharge
1 2 Difficulty breathing
1 2 Sinus trouble
1 2 Recurrent sore throats
1 2 Enlarged glands
1 2 Swollen lymph nodes
1 2 Skin problems If so, what_____
1 2 Hay fever
1 2 Brittleness of nails
1 2 Change in hair texture
1 2 Sleep apnea
1 2 Hoarse voice

Cardio-Vascular-Respiratory

1 2 Chest pain
1 2 Difficulty breathing
1 2 Chronic or frequent cough
1 2 Cough on laying down
1 2 Wheezing
1 2 Shortness of breath
1 2 Palpitations or fluttering of heart
1 2 Blood pressure problems
1 2 Heart problems
1 2 Lung problems
1 2 Cold extremities
1 2 Varicose veins
1 2 Pain in chest, neck or arms With exercise

Genito-Urinary System

1 2 Unexplained soreness of genitals
1 2 Bladder trouble
1 2 Excessive urination
1 2 Do you get up during the night to urinate? How often_____
1 2 Scanty urination
1 2 Painful urination
1 2 Burning urination
1 2 Discolored urination

Women Only Menstrual History

1 2 Unusual vaginal discharge
1 2 Vaginal dryness
1 2 Vaginal bleeding
1 2 Vaginal pain
Date of last pelvic exam_____
Cycle:_____Regular_____
Irregular____ # of Days_____
Flow: heavy___medium____
Light____
1 2 Pains or cramps
1 2 Emotional before period
1 2 Food cravings before period
1 2 Breast pain
1 2 Lumps on breast
1 2 PMS
1 2 Pregnancies_____

Nutrition Questionaire

How many glasses of water do you drink per day?_____
Do you smoke? ___Packs/day?___
Cups of coffee per day_____
Cups of caffeinated tea per day____
Do you drink soda?____yes____no
Do you drink alcohol?___yes___no
How much per week: beer_____
Wine_____ hard liquor_____
Do you eat: (circle **Yes or No**)
Red meat **Y N** How often_____
Whole grains **Y N** How often_____
Fresh veggies **Y N** How often_____
Chicken/fish **Y N** How often_____
Ice cream, pastries, candies, cookies
Y N How often_____
Sugar **Y N** How often_____
Honey **Y N** How often_____
Fresh fruit **Y N** How often_____
Pasta or potatoes
Y N How often_____
Dairy products **Y N**
How often_____
Do you eat breakfast every day? **Y N**
Do you eat between meals?
Are there any foods you avoid?_____
Do you have any known or suspected food allergies?_____
_____
Do you feel that your diet may be excessive or deficient in some respect? **Y N** Describe_____
_____

Lifestyle

How many hours sleep per night do you average?_____
Do you sleep on your side, back or stomach?_____
What do you do for exercise?_____
How many hours per week? _____