PATIENT INFORMATION

Lakeside Chiropractic

Keytag Number: _____

First Name _____ Last Name _____

Gender ☐ M ☐ F Date of Birth _____/_____/_____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ ☐ W ☐ H ☐ C Second Phone _____ ☐ W ☐ H ☐ C

Email _____

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____

Are you Medicare Eligible? ☐ Yes ☐ No

Do you have Health Saving Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

Will you use this location from your: ☐ Home ☐ Office ☐ or Both?

Approximately, how far did you travel to get here today? ☐ 0-3 miles ☐ 3-5 miles ☐ 5-10 miles ☐ 10+ miles

Approximately, how long did it take you to get here today? ☐ 0-5 mins. ☐ 6-10 mins. ☐ 11-15 mins. ☐ 15+ mins

How did your first hear about Lakeside Chiropractic?

_____

If you were referred by someone please tell us who so we may thank them.

_____

_____ _____

(Patient Signature) (Date)

INFORMED CONSENT

Lakeside Chiropractic

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulation through gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column an extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of a government reports an multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain numbness muscle spasm blossom ability headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

1. While rare, some patients may experience short-term aggravations of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
2. There are reported cases of strokes associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustments and the occurrence of stroke Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke make are serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications and surgical procedures given for the same treatments.

Common alternative to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing the *Informed Consent*, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments) the benefits, risks an alternative to chiropractic treatment .

I consent to the chiropractic treatment offered or recommended to me by my Doctor of Chiropractic including spinal adjustments. I intend this consent to applied to all my present and future chiropractic care received from Lakeside Chiropractic.

Dated this _____ day of _____ 20_____

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains dislocations, fractures, disc injuries strokes and paralysis.*

**In California, please initial after reading this statement, above.* Patients initials _____ Doctor's initials _____

_____
(Patient's Name / Print)

_____ _____
(Patient / Legal Guardian Signature) (Date)

_____ _____
(Witness / Employee Signature) (Date)

PATIENT HISTORY

chiropractic

Name _____ Age _____ Date of Birth _____/_____/_____ Gender ☐ M ☐ F

Height _____ ft. ____ in. Weight _____ lbs. Occupation _____ For how long? _____ yrs. _____ mos.

1. Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? _____

2. Reason for today's visit:

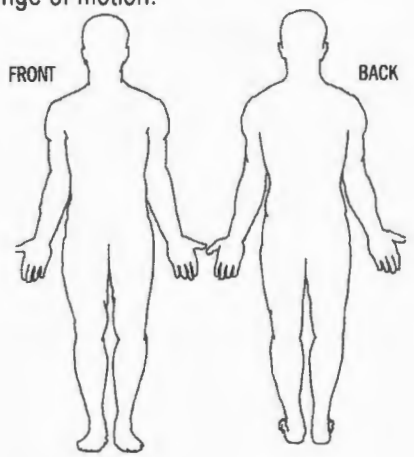
☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other _____

3a. When did your complaint(s) first begin? _____ 3b. Today, is the condition: ☐ Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: _____

4. Where is/are your area(s) of complaint today? *(check all that apply)*	Rate pain/ discomfort between 1-10 *(1 = minimal - 10 = severe)*	Check off the type of complaint and frequency								
		Radiating	Sharp	Dull	Tingling	Numbnes	Burning	Inflamed/ swollen	Constant	Intermittent
☐ Headache/ Migraine										
☐ Neck										
☐ Shoulder(s)										
☐ Arm(s)										
☐ Elbow(s)										
☐ Wrist(s)										
☐ Upper Back										
☐ Middle Back										
☐ Lower Back										
☐ Hip(s)										
☐ Sciatica										
☐ Knee(s)										
☐ Ankle(s)										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



6. Have you experienced this/these complaint(s) before? ☐ Yes ☐ No

if yes, when? _____

7. Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? _____ For Clinic Use Only: BP: _____/ _____

8. Are you currently experiencing any of the following: Double vision Rapid eye movement Numbness on one side of the face or body

☐ Dizziness ☐ Fainting or lightheadedness ☐ Difficulty walking ☐ Difficulty speaking ☐ Headache or neck pain like you have never had before

☐ Difficulty swallowing ☐ Nassea or vomiting *(If yes to any, please describe)* _____

9. Current prescriptions or over-the-counter medications: _____

PAST HISTORY

MUSCULOSKELETAL CONDITIONS (please check all conditions below that apply)

☐ Headaches/Migraines
☐ Neck Pain/Discomfort
☐ Shoulder Pain/Discomfort
☐ Upper Back Pain/Discomfort
☐ Middle Back Pain/Discomfort
☐ Low Back Pain/Discomfort
☐ Hip Pain/Discomfort
☐ Sciatica
☐ Elbow Pain/Discomfort
☐ Wrist Pain/Discomfort
☐ Knee Pain/Discomfort
☐ Ankle Pain/Discomfort
☐ Arthritis
☐ Fused/Fixated Joints
☐ Herniated Disc
☐ Joint Replacement
☐ Osteoporosis
☐ Osteopenia

☐ Inflammation/Swelling: where _____

OTHER CONDITIONS

☐ Cancer
☐ Tumors
☐ Stroke
☐ Seizure Disorders
☐ High Blood Pressure
☐ Pacemaker
☐ Allergies
☐ Other _____
☐ Heart Disease
☐ AIDS/HIV
☐ Diabetes
☐ Hepatitis
☐ Tuberculosis
☐ Hermia

10. Indicate if you have experienced any of the following and mark how recently.

Surgeries?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.
Accidents/Broken Bones?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.
Hospitalizations?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.

If yes to any, list and describe _____

11. Family Health History: *(check all that apply)* ☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

_____

(Patient / Legal Guardian Signature) *(Date)*