

Informed Consent

The risks associated with chiropractic care are generally considered to be low for most people. In many cases they are lower than the risks associated with common medical procedures.

The therapeutic use of heat (hot packs) has been known to cause burns and cryotherapy (cold packs) may cause “frostbite”. Electric stimulation may also cause burns and is generally not recommended for patients with active cancer, implanted defibrillators, pace-makers or who are pregnant. While rare, fractures or injuries to discs, ligaments, arteries, muscles and/or tendons can occur during chiropractic adjustments. Injuries to the arteries of the neck have been associated with strokes and may result in serious neurological impairment or death. The best available evidence suggests that the incidence of stroke is remote – about 1 in several million neck adjustments.¹ To understand this risk in common terms; it is about the same as the risk you’ve already taken by driving here today (assuming a 6 mile trip each way).²

The presence of certain conditions may elevate your risks, such as conditions affecting the integrity of your arteries or bones (ex: cancer, heart problems, aneurysm, stroke, osteoporosis, and others). Provide a thorough and accurate past medical history when completing your intake paperwork and advise your chiropractor if you may be pregnant.

Common alternatives to chiropractic care also have risks. The reported risk of death during cervical spine surgery is 1 in a few hundred.³ The mortality rate from a cervical spine surgery is significantly greater than the risk of stroke associated with chiropractic neck adjustments. There are also risks associated with the medicines most commonly taken for pain relief. Research suggests that approximately one-third of all hospitalizations and deaths related to gastrointestinal bleeding can be attributed to the use of aspirin or ibuprofen.⁴

Finally, there are risks associated with remaining untreated. They potentially include the formation of adhesions, bone spurs, reduced mobility, and disc herniation. In some cases remaining untreated may lead to increased pain and may necessitate interventions which chiropractic management could have prevented. Postponing care now may render future treatment efforts less effective.

I understand that there are risks associated with treatment in this office. I have had the opportunity to discuss my risks, my questions and my concerns to my satisfaction with Dr. David Richards. Having considered the risks, I have decided that it is in my best interest to undergo the treatment recommended. I have been given no guarantee or assurance as to the results which may be obtained from doing so. I have given Dr. Richards my verbal consent and I hereby offer this signed consent to receive the treatments recommended to me. I intend this consent to apply to all present and future treatment that I receive under the care of this office.

Print Name

Date

Signature

If not signed by the patient receiving care, what is your relationship to the patient?

Dr. David Richards, D.C.

References

1. Haldeman S, et al. Arterial dissection following cervical manipulation. *Can Med Assoc J* 2001;165(7):905-06.
2. "IRTAD Database, November 2009 -- Risk Indicators". OECD International Traffic Safety Data and Analysis Group (IRTAD).
3. Wang M, et al. Complications and mortality associated with cervical spine surgery. *Spine*. 2007;32(3):342-347
4. Lanas A, et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those associated with nonsteroidal anti-inflammatory drug use. *Am J Gastroenterol* 2005;100:1685–1693.

Welcome

First Name _____

Last Name _____

Middle Initial _____ Preferred Name _____

Gender M F Date of Birth _____

Address _____

City _____

State _____ Zip code _____

Cell Phone _____

Work Phone _____

Email _____

Status: Single Married Separated Divorced Widowed

Name of spouse (if applicable) _____

Children (names/ages): _____

Whom may we thank for referring you? _____

Have you ever seen a chiropractor before? Y N

Where? _____ When? _____

Employer/Occupation _____

Primary on Insurance Policy: Self Spouse Guardian Other

Name _____

Insured's Employer _____

Date of Birth _____ SSN (optional) _____

Who is responsible for payment: Self Spouse Guardian Other

If not "Self":

Name _____

Address _____

Phone _____

Reasons for today's visit:

- maintenance/wellness care stiffness spasms numbness tingling headache neck pain TMJ arm pain
 shoulder pain lost range of motion elbow pain wrist pain carpal tunnel back pain sciatica disc problem
 sacroiliac pain hip pain leg pain knee pain ankle pain foot pain fibromyalgia auto accident sports related

How and when did your symptoms begin? _____

Describe _____

Nature of your symptoms: dull achy sharp burning numb tingling other _____

Circle pain range, from 0 (none) to 10 (remarkably severe): ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Frequency of pain as percentage of day: constant, 76-100% frequent, 51-75% occasional, 26-50% intermittent, 0-25%

What makes it feel better? (*stretching, ice, heat, etc*) _____

What makes it feel worse? (*bending, lifting, twisting, etc*) _____

When is it worst? (*mornings, evenings, at work, etc*) _____

Affected Activities: Sleep Work Home Chores Walking Standing Sitting Driving Exercise Lifting

Recreation Social Life Reading Travel Other: _____

Authorization: *I have received a copy of the Richards Family Chiropractic HIPAA Privacy Policy (available upon request). I authorize my insurance company to pay to Dr. David Richards and/or Richards Family Chiropractic all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance or not.*

Signature _____ Date _____

Past Medical History

	<i>Describe</i>	<i>Date</i>
Auto Accidents	<input type="checkbox"/> None _____	_____
Falls	<input type="checkbox"/> None _____	_____
Head Injuries	<input type="checkbox"/> None _____	_____
Broken Bones	<input type="checkbox"/> None _____	_____
Dislocations	<input type="checkbox"/> None _____	_____
Surgeries	<input type="checkbox"/> None _____	_____
Artificial Bones/Joints	<input type="checkbox"/> None _____	_____
Other Serious Injuries	<input type="checkbox"/> None _____	_____

List any diagnosis, condition or disease you may have: None

Checkmark (✓) the box that describes your habits:

	Heavy	Moderate	Light	None
Alcohol				
Recreational Drugs				
Tobacco				
Coffee / Caffeine				
Appetite				
Exercise				
Sleep				

Other providers seen for your condition:

Pregnant? Due Date: _____

Check all that apply:

<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Arnold-Chiari Malformation	<input type="checkbox"/> Osteoporosis/Osteopenia
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> History of Spinal Fractures	<input type="checkbox"/> History of Spinal Tumor	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Progressive Numbness	<input type="checkbox"/> Cancer
<input type="checkbox"/> Fever, Chills, Night Sweats	<input type="checkbox"/> Bowel or Bladder Changes	<input type="checkbox"/> Balance Issues

If you currently have any of the following, indicate this with a "C" in the box, if you've had it only in the past, indicate this with a "P":

<p>Eye, Ear, Nose & Throat</p> <input type="checkbox"/> Vision Problems <input type="checkbox"/> Eye Infection / Inflammation <input type="checkbox"/> Ear Pain or Discharge <input type="checkbox"/> Ringing in Ears / Tinnitus <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore Throat or Hoarseness <input type="checkbox"/> Difficult or Slurred Speech <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other _____	<p>Gastro-Intestinal System</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Difficulty Chewing / Swallowing <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Diarrhea / Constipation <input type="checkbox"/> Black or Bloody Stool <input type="checkbox"/> Liver Disease <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Kidney or Adrenal Disease <input type="checkbox"/> Other _____	<p>Cardio-Vascular-Respiratory</p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension (High Blood Pressure) <input type="checkbox"/> Blood Clots or Bleeding Disorders <input type="checkbox"/> Other Vascular Disorders <input type="checkbox"/> Lung Disease <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Asthma <input type="checkbox"/> Other _____
<p>Musculoskeletal System</p> <input type="checkbox"/> Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Arm Problems <input type="checkbox"/> Leg Problems <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Sore Muscles <input type="checkbox"/> Weak Muscles <input type="checkbox"/> Other _____	<p>Nervous System</p> <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Headaches <input type="checkbox"/> Muscle Jerking <input type="checkbox"/> Confusion <input type="checkbox"/> Depression / Psychiatric Problems <input type="checkbox"/> Other _____	<p>Genito-Urinary System</p> <input type="checkbox"/> Discolored Urination <input type="checkbox"/> Urination is Difficult or Painful <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Other _____ <p>Other</p> <input type="checkbox"/> Diabetes (Type I / Type 2) <input type="checkbox"/> Breast Prosthesis or Implant <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> Allergy Problems

This information is thorough and accurate to the best of my knowledge. I understand that this information is necessary to determine the appropriate management of my condition. If there is any change in my medical status, I will inform the doctor.

Signature _____ Date _____

Medications, Allergies and Smoking Status

Completion of this form is optional.

Current medications (if more space is required, use the back of this page)

See attached list.

Name of Medication	Dosage	Reason for taking

Food, environmental and medication allergies (if more space is required, use the back of this page)

Allergy	Reaction	Mild, moderate or severe

Smoking status

(Tobacco)

Never smoked	
Former smoker	
Currently smoke every day	
Currently smoke some days	
Heavy tobacco use daily	
Light tobacco use daily	
Number per day:	

Optional:

Race and ethnicity (check all that apply)

White	
Hispanic	
Asian or Asian American	
Native Hawaiian or Pacific Islander	
Black or African American	
Native American or Native Alaskan	
Additional:	

Language Preference: English Spanish Other _____

This information is thorough and accurate to the best of my knowledge. If there is any change in my medical status, I will inform the office.

Signature _____ Date _____