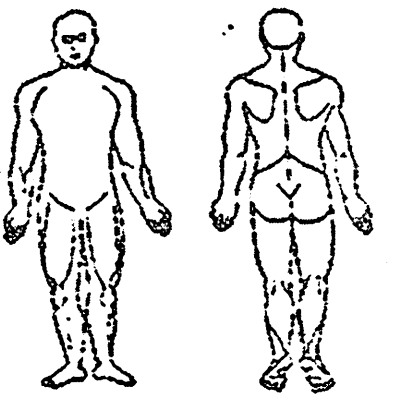
Mars Hill Chiropractic Center

Patient:_____ **D.O.B.**_____**Date:**_____



1. Name your **PRIMARY** complaint and **indicate on diagram** where your pain is:_____
2. Pain is: **Sharp Dull Burning Throb Stabbing numb Ach Other**
3. When did your symptoms start?_____
4. How did your symptoms start?_____
5. average pain intensity:
   in the last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10 worst pain
   in the past week: no pain 1 2 3 4 5 6 7 8 9 10 worst pain
6. How often do you experience your symptoms? (circle below)

   Constantly (75-100% of the time) Frequently (50-75% of the time)

   Occasionally (25-50% of the time)Intermittently (0-25% of the time)

7. How are your symptoms changing? (circle below)

   Getting better **Not changing** **Getting worse**

8. What makes your symptoms worse?_____
9. What makes your symptoms better?_____
10. Have you had this problem examined by anyone else?_____
11. What have you done to treat this problem?_____

Additional complaints:_____

_____

List current medications, including dosage: If there are no current medications, check here: **O**

1._____ 7._____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12._____

List all the surgical procedures you have and any times you have been hospitalized:_____

_____

_____

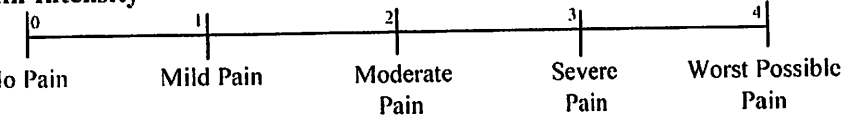
_____

Mars Hill Chiropractic Center

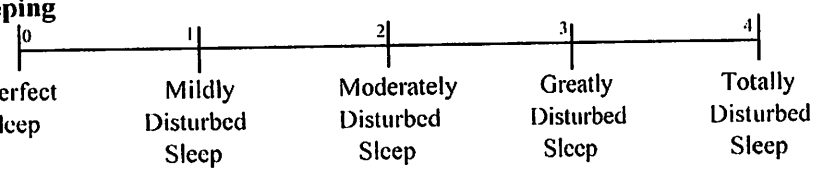
Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

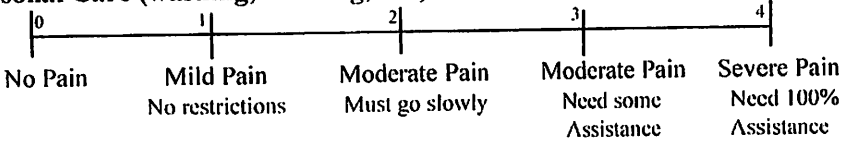
1. Pain Intensity



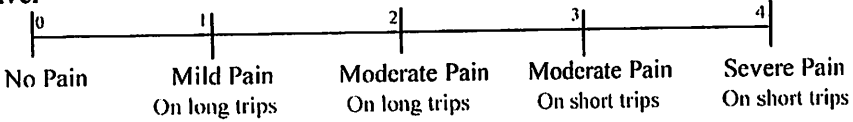
2. Sleeping



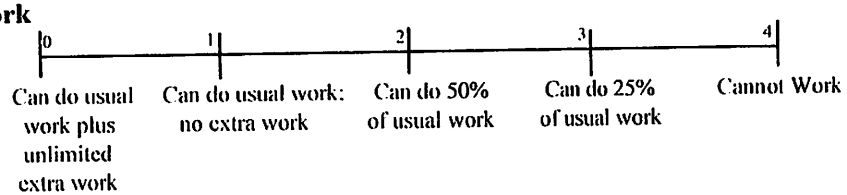
3. Personal Care (washing, dressing, etc.)



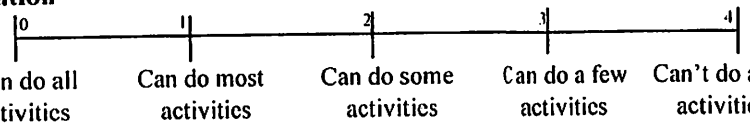
4. Travel



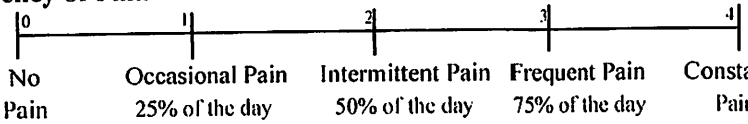
5.Work



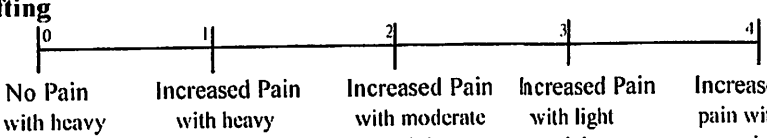
6. Recreation



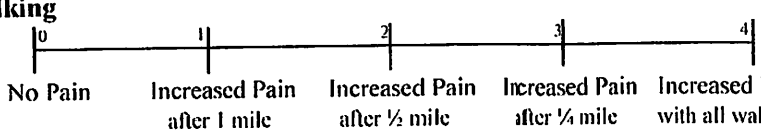
7. Frequency of Pain



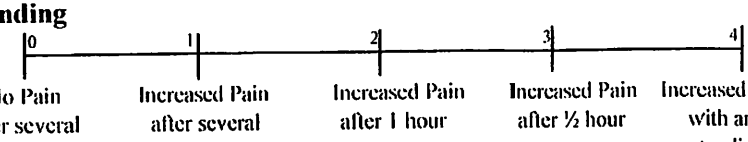
8. Lifting



9. Walking



10. Standing



Patient Name: _____

Signature: _____

Date: _____

Informed Consent to Chiropractic Care

We provide adjustments, or manual manipulations, through the 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 and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasms, loss of mobility, 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:

- While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle and ligament strains or sprains as a results of manual therapy techniques.
- There are reported cases of stroke 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.
    - The apparent associated is noted very infrequently, however, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
- There are reported cases of disc injury following a 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 alternatives to adjustments and manipulations include medications, physical therapy, or medical treatments and surgery provided by physicians and surgeons.

Dry needling is a technique that utilizes thin, solid filament needles. This needling technique is used specially to treat myofascial trigger points, muscle spasms, or dysfunctional tissue. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur. They include pain, infection, bruising or bleeding, drowsiness, fatigue and autonomic responses, and pneumothorax.

By signing this 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, and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care received from Mars Hill Chiropractic Center.

Patient Printed Name: _____

Patient Signature: _____

Legal Guardian Signature: _____

Witness Signature: _____ Date: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which Mars Hill Chiropractic Center may have to see or use your health care information. We may have to disclose your health information:

- To another health care provider for referral to them for treatment or diagnosis
- To an insurance company or another party if the are responsible for payment of your services for treatment
- Amongst the staff within our practice for quality control or administrative purposes

Your right to limit uses or disclosures

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Mars Hill Chiropractic Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mars Hill Chiropractic Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Patient Name: _____

Signature: _____ Date: _____