Family Chiropractic Prevention Center
7550 Oswego Road
Liverpool, NY 13090
315.453.4040
www.WeCare4Families.com

Date: _____/_____/_____

Name: (FIRST)_____(MI) _____(LAST) _____Circle: MALE / FEMALE

Cell Phone: ( ) _____-_____ Home Phone: ( ) _____-_____

E-mail (please print) _____

Birth Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Marital Status: Married Widow Divorced Single Spouse / Significant Others Name: _____

Name of Children: _____

Many patients are referred to the office by friends, family, or other doctors. Who or what made you decide to visit us today?

_____

Name of Insured (person who maintains your insurance benefit):_____ Circle: MALE / FEMALE

Insured Date of Birth: _____/_____/_____Insured Employer: _____

Science tells us your spine should be cared for regularly. How often do you get a chiropractic adjustment?

FREQUENTLY ONLY WHEN HURT 1 X A WEEK NEVER

When was your last spinal examination including x-rays? Date: _____ NEVER

Name of your most recent Chiropractor_____

Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? YES NO

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, crack or pop your back or neck. Are you forcibly doing this to your neck or back? YES NO

Poor posture leads to poor health and early death. Please rate your posture? POOR FAIR GOOD EXCELLENT

Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? YES NO

Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in?
BACK STOMACH RIGHT SIDE LEFT SIDE

Please list any surgeries you've had:

Type of Surgery	Date

Is this a current work or auto related accident? YES NO

Are you currently represented by an attorney? YES NO

Patient name:_____ Date:_____

Previous Injury or trauma (Ie. Auto Accident, major slips & falls) _____

_____

Have you ever broken any bones? Which? _____

Any allergies: _____

Prescription medications can cause various side effects that hide the severity of health problems and hinder the body's ability to heal. Please indicate below the prescription medications you are currently taking? (use back if necessary):

Name of Medication/including OTC	Dose/Frequency	Reason for Taking

Please list any vitamins/supplements you take:

Vitamin/Supplement	Dose/Frequency	Reason for Taking

COVID Vaccines:

How many COVID-19 vaccination/boosters have you received:_____ What was the date of the last booster:_____

Did you have any reaction to the COVID-19 vaccination/boosters: (please circle all that apply)

None Fever Headache Clotting Cardiac Issues

Other:_____

Do you have a personal history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases □ Adopted/Unknown □ Cardiac disease below age 40

□ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases □ Adopted/Unknown □ Cardiac disease below age 40

□ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

Date: _____

Tobacco / Nicotine Use: ☐ None ☐ Former ☐ Current Type: ☐ Cigarettes ☐ Vaping ☐ Other: _____

☐ Light (1–10/day) ☐ Moderate (11–20/day) ☐ Heavy (21+/day)

Do you use marijuana/cannabis: ☐ NO ☐ YES Type: ☐ Smoking ☐ Vaping ☐ Edibles ☐ Other: _____

Frequency: ☐ Rare ☐ Weekly ☐ Frequent ☐ Daily

Do you use any recreational substances? ☐ No ☐ Yes

Over-the-Counter (OTC) Medication Use (e.g., ibuprofen, Tylenol, Advil, supplements)**:** ☐ No ☐ Yes

If yes, what do you take: _____

How often: ☐ Occasionally ☐ Daily ☐ As needed

Caffeine Use: ☐ None ☐ 1/day ☐ 2–3/day ☐ 4+/day Source: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy drinks ☐ Other: _____

What is your alcohol intake:

☐ No Alcohol ☐ social drinker ☐ light drinker ☐ moderate drinker ☐ heavy drinker ☐ struggles w/alcohol

Tell us about your work habits (please check all that apply)

Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Not working

Hours/week: ☐ 0–20 ☐ 20–40 ☐ 40–60 ☐ 60+

Activity: ☐ Sitting ☐ Standing ☐ Walking ☐ Light ☐ Moderate ☐ Heavy labor

Hours sitting per day: ☐ <2 ☐ 2–4 ☐ 4–6 ☐ 6+

Tasks: Computer ☐ Repetitive ☐ Lifting ☐ Driving ☐ Phone ☐ **Stress:** ☐ Low ☐ Moderate ☐ High

Tell us about your stress: (please circle all that apply)

Overall stress level (past 2–4 weeks):Low ☐ Moderate ☐ High ☐

How often do you feel stressed?

☐ Rarely ☐ Occasionally ☐ Frequently ☐ Constantly

Primary sources of stress (check all that apply):

☐ Work ☐ Home / family ☐ Emotional / mental ☐ Physical (pain, injury) ☐ Chemical (diet, caffeine, medications)

Does stress affect your symptoms? ☐ No ☐ Sometimes ☐ Yes

How often do you exercise?
☐ Rarely / never
☐ 1–2x per week
☐ 3–4x per week
☐ 5+ times per week

Type of activity (check all that apply):
☐ Walking / light activity ☐ Cardio (running, cycling, etc.)
☐ Strength training ☐ Flexibility (yoga, stretching, Pilates)
☐ Sports / recreational activities ☐ Physical therapy / rehab

Intensity:
☐ Light ☐ Moderate ☐ High

Review of Systems:

Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other_____ □None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Patient Name: _____ Date: _____

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell

□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroids □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Anxiety □ Other_____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

Patient name: _____ Date: _____

Please indicate the symptoms that brought you in today –
Start with the area of most pain /difficulty--
Problem 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name:_____ Date:_____

(IF YOU DO NOT HAVE ANY ADDITIONAL CONCERNS, PLEASE LEAVE THIS PAGE BLANK)

Please indicate the symptoms that brought you in today: --Second biggest problem

ADDITIONAL CONCERN #2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name:_____ Date:_____

(IF YOU DO NOT HAVE ANY ADDITIONAL CONCERNS, PLEASE LEAVE THIS PAGE BLANK)

Please indicate the symptoms that brought you in today: --Third biggest problem

ADDITIONAL CONCERN #3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name: _____ Date: _____

(IF YOU DO NOT HAVE ANY ADDITIONAL CONCERNS, PLEASE LEAVE THIS PAGE BLANK)

Please indicate the symptoms that brought you in today: --fourth biggest problem

ADDITIONAL CONCERN #4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

If the doctor identifies your spine to be misaligned, are you committed to following the recommendations to correct your problem completely?

YES NO

What are your treatment and health goals? (Please circle all that apply)

Corrective care	relief care	Posture Correction	return to pre-injury status
Preventative care	increased overall health	Pain Management	Better Balance

As you view the activities, please circle the area of pain the corresponds to that activity:

Housework **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Shopping **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Driving **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Social outings **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Care of pets **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Child care **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Dressing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Climbing stairs **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Walking **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Shoveling **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Computer work **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Yard work **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sex **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sitting **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Standing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Getting out of tub **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sleep **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Mood **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
In/out of car **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Exercising **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
In/out of bed **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Paying attention **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Bowel movements **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Energy level **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sitting to standing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Putting shoes on **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs

Thank you for the opportunity to better serve you.

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and practice member.**

- **Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account, there will be a $5.00 late charge or a 1.5% per month late fee whichever is greater.**

- **We will make every attempt to get your insurance to approve your care. We will keep you up to date on the status of your coverage. Often it is difficult to get your insurance to acknowledge the practice member's complete health care needs over their own financial concerns. However, we will not compromise the quality of the health care we provide. Our responsibility is to you, our practice member, first and foremost.**

- **The thermal subluxation scan is not reimbursed by your insurance carrier. The $35.00 charge is the patient's responsibility.**

There will be a $50.00 charge in addition to your normal co-pay for all emergency visits.

- **I consent to event photos taken in the office being used in the office, on Family Chiropractic's website and social medial ie. Facebook, Instagram.**

- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process any insurance claims.**

- **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.**

- **Any balance that is left unpaid by your insurance company is your sole responsibility.**

Signature (Practice Member/Guardian)_____ Date:_____/____/_____

I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Chiropractic Prevention Center's Privacy notice and discuss any questions I may have regarding HIPPA with the doctor and/or the staff.

Leave appointment messages on:	Leave other medical/insurance info on:	Special Services, Events, New Health Info, website/Facebook photos on:
ANY OF THE BELOW ☐	**ANY OF THE BELOW** ☐	**ANY OF THE BELOW** ☐
Answering machine	Answering machine	Answering machine
Cell phone or text message	Cell phone or text message	Cell phone or text message
Office voice mail	Office voice mail	Office voice mail
Email	Email	Email
w/Person(s) listed below	w/Person(s) listed below	w/Person(s) listed below

Any person(s) at home phone #: Y / N

Person(s) authorized to discuss the above:

_____ Relationship _____

_____ Relationship _____

Signature (Practice Member/Guardian) _____ Date:_____/_____/_____

I consent to have the Practice use and disclose my protected health information for treatment, and health care operations purposes, and for such other purposes that are permitted under HIPPA

Signature (Practice Member/Guardian)_____ Date:_____/_____/_____

Pregnancy Release

Are you currently pregnant: No □ Yes □ If yes how many weeks?_____ What is your due date: _____

This is to certify that to the best of my knowledge I am **not pregnant,** and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature Date

Informed Consent for Chiropractic Care

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Dr. Steven Klink & Family Chiropractic TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Print Name Signature Date

Doctor Signature

Parental Consent for Minor Patient:

Patient Name: _____ Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for:

Patient: _____Signature: _____Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for:

Patient: _____Signature: _____Relationship to Patient: _____

Remarks: