Temecula Center for Integrative Medicine

Chiropractic Paperwork
Patient Information

Please fill out information neatly and accurately

Last Name: _____ First: _____ MI: ____ DOB: ____/____/_____ Sex: M___ F___

Street: _____ Apt#: _____ City: _____ St: _____ Zip: _____

Best Contact #: _____/_____ Optional #: _____/_____ Email address: _____

Patient a minor? YES ☐ NO ☐ If yes, please provide contact name and relationship: _____

S.S.#: _____-_____-_____ Primary Care Physician_____ Phone#_____/_____

☐ Married ☐ Single ☐ Divorced ☐ Other Spouse's Name:_____ Spouse's Contact #: ____/_____

Emergency Contact (not living with you): _____ Phone #: _____/_____

How did you hear about us? ☐ Social Media_____ ☐ Referral by_____ ☐Other_____

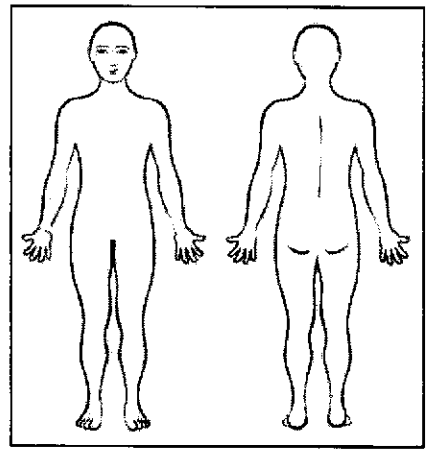
Patient Condition

Reason for Visit:_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐Shooting ☐ Burning ☐Tingling ☐ Cramps ☐ Stiffness

☐Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Full name and Specialty of other doctor(s) who have treated you for your condition _____

Date of Last:

Spinal X-Ray _____ obtained by:_____ Chest X-Ray_____ obtained by:_____

Dental X-Ray _____ obtained by:_____ MRI, CT-Scan, Bone Scan_____ obtained by:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Type:_____		Migraine Headaches	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Type:_____		Migraine Headaches	☐ Yes ☐ No	Tumors/Growth	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema/COPD	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Other _____	
Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	_____	

Exercise

Current Exercise Program

Type	Frequency/ Week	Duration in Minutes

☐ Drug Addiction: How many years?_____ Drug:_____/_____

☐ Smoking
How many years? _____ Packs per day: Past_____ Present_____
Attempts to quit: _____ Using what methods:_____

☐ Alcohol ☐ Coffee/ Caffeinated Drinks
Drinks per week: _____ Cups per day: _____

Stress Level: ☐ High ☐ Moderate ☐ Minimal ☐ Managed ☐ Unmanaged
Reason:_____

Work Activity

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy labor

Injuries/Surgeries

Past Injury/Surgery	Description	Date
Falls:		
Head Injuries:		
Fractures:		
Dislocations:		
Surgeries:		

Medication/Supplement History

(attach separate page if needed)

Current Medications

Medication	Strength	Dosing Schedule	Start Date	Reason for Use?

Current Nutritional Supplements *(Vitamins/Minerals/Herbs/Homeopathy)*

Medication	Strength	Dosing Schedule	Start Date	Reason for Use?

Allergies *(Environmental, Food & Drugs)*

Allergen	Associated Symptoms	Treatment Needed, If Applicable

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or test conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is know as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our heads or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/ or temporary increase in symptoms, lack of improvement of not limited to: muscle spasms, aggravating and/ or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs, and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes there is a rare but serious condition as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection a normal, healthy artery. Disease processes, genetic disorders, medication, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial DIssections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) Gi tract was 1219 events/per one million person/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other that chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have read to me, the above consent. I appreciate that it is not possible to consider every complication with care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____
PRINTED

_____
Signature

_____
Date

Review of Symptoms Questionnaire

Have you been feeling any of these symptoms recently?

General	☐ Fever	☐ Fatigue	☐ Night sweats	☐ Insomnia
HEENT	☐ Vision changes	☐ Headaches		
Respiratory	☐ Shortness of breath	☐ Cough		
Cardiovascular	☐ Chest pain	☐ Palpitations		
Vascular	☐ Leg cramps with exercise			
Gastrointestinal	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Indigestion
Genitourinary	☐ Burning with urination	☐ Blood in urine		
Metabolic/Endocrine	☐ Cold intolerance	☐ Heat intolerance		
Neuro/Psychiatric	☐ Dizziness	☐ Anxiety	☐ Depression	
Dermatologic	☐ Rash	☐ Itching		
Musculoskeletal	☐ Back pain	☐ Joint pain		
Hematologic	☐ Easy bruising	☐ Easy bleeding		
Immunologic/Allergy	☐ Food allergies	☐ Environmental allergies		

Any other symptoms not mentioned above?

Name: _____ **Date:** _____

Doctor's Note