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 5.85 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] Put one more way, a person is approximately 900 times more likely to be struck by lightning during their lifetime[3].

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 333 (for patients aged 20-34).[4] The mortality rate from cervical spine surgery is approximately 17,000 times 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.[5]

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. *National Oceanic and Atmospheric Administration. http://www.lightningsafety.noaa.gov/medical.htm*
4. *Wang M, et al. Complications and mortality associated with cervical spine surgery. Spine. 2007;32(3):342-347*
5. *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 _____Nickname _____

Address _____

_____

City _____

State _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail _____

Sex ☐M ☐F Date of Birth _____

Status ☐Single ☐Separated ☐Married ☐Widowed ☐Divorced

Name of spouse (if applicable) _____

Whom may we thank for referring you? _____

How did you first hear of this clinic? _____

Have you ever seen a chiropractor before? ☐Y ☐N

Where? _____ When? _____

Employer/Occupation_____

Who is responsible for payment? ☐Self ☐Spouse ☐Guardian ☐Other

If not "Self":
Name_____
Address_____
Phone(s)_____

Who is the primary insured? ☐Self ☐Spouse ☐Guardian ☐Other

If not "Self":
Name_____

Insured's Employer _____

Date of Birth _____ SSN (optional) _____

Children (names/ages)_____

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

Describe _____

When and how did symptoms begin? _____

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

Circle pain range, from 0 (none) to 10 (remarkably severe): ⓪ 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 you feel better? *(stretching, ice, heat, etc.)* _____

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

What activities do your symptoms restrict? _____

Authorization:

I have received a copy of the NOTICE OF PATIENT PRIVACY POLICY and I give permission to use or disclose my protected health information in the manner it describes. 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

		Describe	*Date*
Auto Accidents	☐ None		
Falls	☐ None		
Head Injuries	☐ None		
Broken Bones	☐ None		
Dislocations	☐ None		
Surgeries	☐ None		
Artificial Bones/Joints	☐ None		
Other Serious Injuries	☐ None		

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

_____

_____

_____

_____

_____

_____

Other providers seen for your condition:

_____

_____

Checkmark (✓) the box that describes your habits:

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

Indicate if you have ever had:

☐ Pacemaker/Defibrillator ☐ Spinal Tumor ☐ Spinal Surgery ☐ Rheumatoid Arthritis ☐ Arnold-Chiari Malformation ☐ Syringomyelia

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":

Eye, Ear, Nose & Throat

- ☐ Vision Problems
- ☐ Eye Infection / Inflammation
- ☐ Ear Pain or Discharge
- ☐ Ringing in Ears / Tinnitus
- ☐ Hearing Loss
- ☐ Sore Throat or Hoarseness
- ☐ Difficult or Slurred Speech
- ☐ Sinus Problems
- ☐ Allergy Problems
- ☐ *Other* _____

Gastro-Intestinal System

- ☐ Poor Appetite
- ☐ Difficulty Chewing / Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea / Constipation
- ☐ Black or Bloody Stool
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ *Other* _____

Cardio-Vascular-Respiratory

- ☐ Chest Pain
- ☐ Heart Problems
- ☐ Blood Pressure Problems
- ☐ Vascular Disorders
- ☐ Lung Problems
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ *Other* _____

Musculoskeletal System

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Shoulder Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ *Other* _____

Nervous System

- ☐ Numbness, *where* _____
- ☐ Spasms, *where* _____
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle Jerking
- ☐ Confusion
- ☐ Depression / Psychiatric Problems
- ☐ Insomnia
- ☐ *Other* _____

Genito-Urinary System

- ☐ Bladder Trouble
- ☐ Discolored Urination
- ☐ Urination is Difficult or Painful
- ☐ Sexually Transmitted Disease
- ☐ *Other* _____

Miscellaneous

- ☐ Breast Prosthesis or Implant
- ☐ Pregnant, due date: _____
- ☐ Cancer: _____
- ☐ Osteoporosis
- ☐ *Other* _____

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

Federal guidelines require that we track statistics relating to race, ethnicity, language, smoking, allergies and medication use.

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*

Current smoking status

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

Your Race and ethnicity *(check all that apply)*

☐ *Non-Hispanic* ☐ *Hispanic*

White	
Asian or Asian American	
Native Hawaiian or Pacific Islander	
Black or African American	
Native American or Native Alaskan	

Preferred language: ☐ English ☐ Spanish ☐ Other_____

Why we need your email address

Your email address helps us to comply with federal guidelines. It will be used for appointment reminders and to enable secure access to your patient health record (PHR), both of which are now required by federal guidelines. Your email address is never shared. You will not receive spam, offers, or junk mail.

Email address _____

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 _____