# Vero Walk-In Chiropractic & Wellness Patient Information

Please Print:

Name: _____ Birthdate: _____

Address: _____

City : _____ State: _____ Zip: _____

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

Please circle: Male Female Married Single Widowed Divorced Separated

Home Phone: _____ Cell Phone : _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____ # of years: _____

Spouse or Parent Name: _____ Birthdate: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Name of Local Primary Physician: _____ May we contact them? _____

Who may we thank for referring you to us? _____

Did you see our: Website Facebook Business Sign Word of Mouth

**Symptoms**

Main complaint: _____

When did it start? _____ How did it start? _____

What activity bothers it the most? _____ Getting Better/Worse? _____

When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working

Rate the pain (0 Pain Free – 10 Unbearable Pain) 0 1 2 3 4 5 6 7 8 9 10

Secondary complaint: _____

Other chiropractors? _____ Positive experience? _____ Last visit? _____

Other type of physician or therapist? _____ Positive experience? _____

**Health History-**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Allergy Shots | Anemia | Anorexia | Appendicitis | Arthritis | Asthmas | Bleeding | Stroke |
| Breast Lump | Bronchitis | Bulimia | Cancer | Cataracts | Chicken Pox | Depression | Diabetes | Thyroid |
| Emphysema | Epilepsy | Fractures | Glaucoma | Goiter | Gonorrhea | Gout | Heart Dx | Implants |
| Hepatitis | Hernia | Herniated Disc | Herpes | HI Cholesterol | Kidney Dx | Liver Dx | Measles | Prostate |
| Migraines | Miscarriage | Mono | M.S. | Mumps | Osteoporosis | Pacemaker | Parkinson's | Polio |
| Pneumonia | Prosthesis | Rheumatoid | Chronic Fatigue | HI Blood Pressure | Fibromyalgia | Other: _____ | | |

Women- How many children? _____ Are you currently pregnant? _____ Nursing? _____

Taking birth control pills? _____ Date of last menstrual cycle? _____

Previous surgeries and dates: _____

List all medications you are currently taking: _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

*All above questions have been answered accurately and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less that the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient Signature: _____ Date: _____

# Acknowledgement of Receipt of Notice of Privacy Practices

Please check one of the following:

_____ I acknowledge that I have declined the opportunity to receive a paper copy of the Notice of Privacy Practices but I understand it is available to read at any time upon request.

-OR-

_____ I acknowledge that I wanted and was provided a paper copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices.

I understand this form will be placed in my patient chart and maintained for 6 years.

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Patient Name Printed

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Signature of Patient/Parent/Legal Guardian

*Optional
All medical records on file with Vero Walk-In Chiropractic & Wellness are kept private and confidential. However, I authorize Vero Walk-In Chiropractic & Wellness to discuss my medical history/treatment with the following individuals: _____ (initials)

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*This information will remain on file for 6 years unless informed otherwise by the above named patient.

# Informed Consent to Chiropractic Treatment

The Nature of Chiropractic treatment: The Doctor of Chiropractic may perform an examination of the area of complaint and if medically necessary, s/he may take radiographs in order to correctly diagnose the condition. The doctor uses their hands or a mechanical device to move your joints. You may hear a "click" or a "pop" similar to your knuckles cracking and you may feel the joint moving. Additional therapies such as myofascial release, ice, electric muscle stimulation or cold laser may also be used. The doctor will make a very reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. These complications could include but not limited to: fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Some patients may feel stiff and sore after the first few days of treatment.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

Other Treatments which could be considered outside this office may include: over the counter analgesics and rest, medical care including medically prescribed anti-inflammatories, tranquilizers, analgesics, medical pain management including injections, hospitalization or surgery.

Risks of Remaining Untreated: Delay of treatment may allow the formation of adhesions, scar tissue, and other degenerative changes which can further decrease skeletal mobility and induce chronic pain cycles. Over time, this process may complicate the condition and make future rehabilitation more difficult.

I, _____, have read the above explanation of chiropractic treatment and will present any questions that I may have to the doctor. By signing below I state that I have weighed the risks involved in undergoing treatment. I have freely decided to undergo the recommended treatment and I give my full consent to treatment.

_____

Date

_____ _____

Patient's Signature Doctor's Name

_____ _____

Signature of Parent/Guardian if Minor Doctor's Signature