

# Cole Chiropractic & Massage Clinic

Tracy D Cole, D.C. 785 E. Washington, Ste. 5 Crescent City, CA 95531 (707) 464-2921 fax (707) 464-2131

## REQUIRED FOR YOUR CASE HISTORY

Full Legal Name \_\_\_\_\_ Name You Prefer \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Number of Children \_\_\_\_\_

Spouse's Address \_\_\_\_\_ Telephone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

How Were You Referred? \_\_\_\_\_ Name \_\_\_\_\_

**Check One**  Married  Single  Widowed  Divorced  Separated

Have You Had Past Chiropractic Care?  Yes  No

If Yes Previous Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Who Is Your Primary Physician? \_\_\_\_\_

Major Symptom for your visit today? \_\_\_\_\_

Secondary Symptoms? \_\_\_\_\_

Has A Physician Treated You For Any Health Condition In The Last Year?  Yes  No

If Yes Please Explain \_\_\_\_\_

Date Symptom First Began? \_\_\_\_\_ How Did Your Symptom First Begin \_\_\_\_\_

Is Your Pain:  Constant  Intermittent Is Your Condition Getting:  Worse  Better  Stays the Same

What Activities Aggravate Your Condition? \_\_\_\_\_

What Activities Lessen Your Symptoms? \_\_\_\_\_

What Medications Are You Taking? \_\_\_\_\_

Is Condition Worse During Certain Times Of The Day? \_\_\_\_\_

Is This Condition Interfering With: Work, Sleep, Daily Routine? (Check all that applies)

Other Doctors You Have Seen For This Condition? \_\_\_\_\_

Have You Ever Had: Surgery: Yes No Fractures: Yes No Car Accidents:  Yes  No

Falls:  Yes  No On the Job Injury:  Yes  No, Please Describe: Previous \_\_\_\_\_

Serious Illness /Hospitalizations: Please Date And Describe \_\_\_\_\_

If You Are Female Are You Possibly Pregnant? Yes No Date Of Last Menstrual Period \_\_\_\_\_

Family History Of: Heart Disease Yes No Cancer Yes No Diabetes Yes No

Arthritis Yes No Back Problems Yes No Other \_\_\_\_\_

**Have You Ever Had Or Now Have Any Of The Following?**

If Condition Is Current Please Mark With A C If It Is A Previous Condition Please Mark With A P.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Pins & Needles In Legs            | <input type="checkbox"/> Face Flushed                |
| <input type="checkbox"/> Neck Pain or Stiffness        | <input type="checkbox"/> Numbness In Fingers               | <input type="checkbox"/> Loss of Smell Loss of Taste |
| <input type="checkbox"/> Mid Back Pain or Stiffness    | <input type="checkbox"/> Numbness In Toes                  | <input type="checkbox"/> Nausea or Vomiting          |
| <input type="checkbox"/> Low Back Pain or Stiffness    | <input type="checkbox"/> Pain or Trouble Breathing         | <input type="checkbox"/> Cold Feet or Hands          |
| <input type="checkbox"/> Nervousness                   | <input type="checkbox"/> Fatigue or Weakness               | <input type="checkbox"/> Arm or Shoulder Pain        |
| <input type="checkbox"/> Tension or Irritability       | <input type="checkbox"/> Digestive or Eating Problems      | <input type="checkbox"/> Anemia                      |
| <input type="checkbox"/> Leg Cramps or Swelling        | <input type="checkbox"/> Stomach Upset/Pain                | <input type="checkbox"/> Loss of Memory              |
| <input type="checkbox"/> Chest Pain                    | <input type="checkbox"/> Blood In Urine Or Stool           | <input type="checkbox"/> Sexual Dysfunction          |
| <input type="checkbox"/> Dizziness or Light headedness | <input type="checkbox"/> Constipation or Diarrhea          | <input type="checkbox"/> Fever                       |
| <input type="checkbox"/> Headache Seizures             | <input type="checkbox"/> Fainting or Convulsions           | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Pins & Needles In Arms        | <input type="checkbox"/> Loss of Balance or Coordination   | <input type="checkbox"/> Thyroid Problems            |
| <input type="checkbox"/> Buzzing or Ringing In Ears    | <input type="checkbox"/> Sleeping Problems                 | <input type="checkbox"/> High Blood Pressure         |
| <input type="checkbox"/> Kidney Trouble                | <input type="checkbox"/> Arm Shoulder Weakness             | <input type="checkbox"/> Breast Problems             |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Asthma or Emphysema               | <input type="checkbox"/> Prostate Problems           |
| <input type="checkbox"/> Heart Trouble or Stroke       | <input type="checkbox"/> Leg or Foot Pain                  | <input type="checkbox"/> Rashes                      |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Sin us Trouble or Allergies       | <input type="checkbox"/> Loss of Energy              |
| <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Rheumatic Fever                   | <input type="checkbox"/> Abnormal Menstruation       |
| <input type="checkbox"/> Arthritis or Bursitis         | <input type="checkbox"/> Difficulty or Pain With Urination |  |

**Check If You Have Had Any Of The Following Symptoms In The Last 30 Days.**

- Pain Worse at Night Constant Pain Unrelated To Motion Unexplained Weight Loss Surgery  
Loss Of Bowel or Bladder Control Bacterial Infection Fever or Chills

**Check If You Have Had Any Of The Following:**

- History Of Cancer History Of HIV Use Of Steroids Use of IV Blood Transfusions

**NOTICE TO NEW PATIENTS:** Full payment is due at the end of each visit for services rendered.

**Agreement For Patients With Insurance:** I will pay all co-payments or unmet deductible balances at the time services are rendered. I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. I authorize the release of any information pertinent to my case to the insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent to Care

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**Tracy D Cole, D.C.** . 785 E. Washington, Ste. 5 Crescent City, CA 95531 (707) 464-2921 fax (707) 464-2131

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 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 tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands 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 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 known 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 a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, 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 million 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 persons/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 than 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 had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to 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 \_\_\_\_\_

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## Acknowledgement of Receipt of Notice of Privacy Practice

*This form will be retained in your medical record.*

### Notice To Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of **Cole Chiropractic and Massage Clinic**.

I understand the Notice describes the uses and disclosures of my protected health information by Cole Chiropractic and Massage Clinic.

\_\_\_\_\_  
Patient's Signature or that of Legal Representation

\_\_\_\_\_  
Printed Name of Patient or that of Legal Representation

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
If Legal Representation, Indicate Relationship

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of policy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- Communication barriers prohibited obtaining the acknowledgement.
- Other (please specify): \_\_\_\_\_

Employee Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

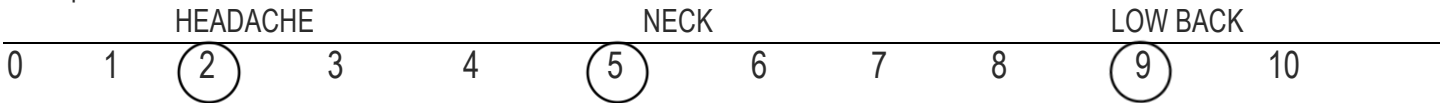
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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

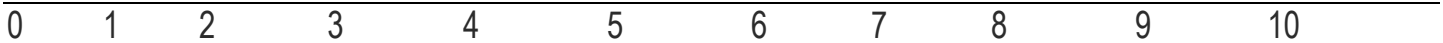
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for what complaint

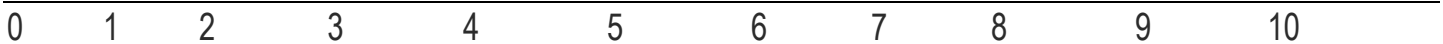
Example:



1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain



3. What is your pain AT ITS BEST (How close to '0' does your pain get at its best?)



What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

Reference: Thomee' R, Grimby G, Wright B.D, Linacre J.M. (1995) Rasch analysis of Visual Anmalog Scale, Scandinavian Journal of Rehabilitation medicine 27, 145-151.

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