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.

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

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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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:

	HEADACHE				NECK				LOW BACK	
0	1	(2)	3	4	(5)	6	7	8	(9)	10

1. What is your pain RIGHT NOW?

0	1	2	3	4	5	6	7	8	9	10

2. What is your TYPICAL or AVERAGE pain

0	1	2	3	4	5	6	7	8	9	10

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

0	1	2	3	4	5	6	7	8	9	10

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)

0	1	2	3	4	5	6	7	8	9	10

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.