Peter Christensen Health Center

Chiropractic Patient Update

Today's Date _____

Name: _____ Date of Birth: _____

Name I prefer to be called: _____

Chief Health Concern

What is your major concern: _____

Other Concerns: _____

How long have you had this condition: _____

How did it originally occur: _____

What relieves the pain: Cold Chiropractic Care Massage Resting Movement Walking Sleeping Medication Warmth Exercise Bending Forward Sitting Leaning while sitting Other: _____

When does it feel better: No Change Morning As day progresses Evening During the night

What makes the pain worse: Resting Sleeping Walking Working Movement Lying down Driving Turning Sitting Standing Lifting Reaching Running Coughing Bending forward Lying on side Sitting to standing position Other: _____

When does it feel worse: No change Morning As day progresses Evening During the night

Have you had spinal x-rays, MRI, CT scan for your areas of complaint? Yes No

Is this condition progressively getting worse: Yes No Constant Comes and goes Improving

Is this condition interfering with your: Work Sleep Daily routine Enjoyment of life

Have you ever had the same or similar condition: Yes No If yes, please describe: _____

_____

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

List previous diagnoses and treatments you have received for present condition:

_____

Are there any other conditions or symptoms that may be related to your major symptom: Yes No
If yes, please describe: _____

Is the condition we are treating related to current or previous employment?:

_____

Is the condition we are treating related to an auto accident or any other type of accident?:

_____

Personal History

Have you received chiropractic spinal adjustments before?: Yes No
If yes, when was your last visit?: _____

How much water do you drink each day?: _____

Functional Rating Index

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, 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 ½ mile	Increased pain after ¼ 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 ½ hour	Increased pain with any standing

Name: _____(Printed) Date of Birth: _____

Signature: _____ Date: _____ Total Score: _____

The State of Wisconsin requires every patient to be informed of the risks of treatment and the alternatives to treatments prior to the beginning of care. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

The nature of chiropractic treatment. The doctor will use his/her hands or a mechanical device in order to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures including electric muscle stimulation, therapeutic ultrasound, laser therapy as well as exercise instruction may be performed.

Possible risks and probability. There are inherent risks in chiropractic and all treatment derived by any health care provider. Although we take every precaution, there are indeed some risks to chiropractic adjustments/manipulations. The risks involved in treatment to the spine excluding the neck are from the least to the most serious may include muscular strain (rare), ligamentous sprain (rare), fractures (rare), injury to the intervertebral discs, nerves, or spinal cord (very rare). The risk involved in the treatment of the neck would include any of the preceding list and the remote possibility of cerebrovascular injury, or stroke, which are very rare. A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary therapies may produce skin irritations, burns or other minor complications (rare).

Other treatment options to be considered but are not provided by the Chiropractic Department may include the following:
Over-the-counter analgesics. The risks of these medications include irritations to the stomach, liver and kidneys and other side effects in a significant number of cases.
Anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above. Patient dependence occurs significantly in a number of cases.
Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated. Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition, and make further rehabilitation more difficult.

Concerns or questions. Please ask your Doctor of Chiropractic. We have gone to great lengths to make your health and safety are a top priority. We will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____	_____
Printed Name	DOB	Signature	Date

For a minor or person represented by another party.

_____

If you sign on behalf of the patient give the description of the authority to act on behalf of the patient(Parent, guardian…)

_____	_____
Witness	Date