Maple Ridge Chiropractic & Massage

New Patient Intake Form

Patient Information

Name: _____ Date of Birth: _____Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____Email: _____ Gender: □ Male □ Female
How did you hear about our office?_____
Emergency Contact Name: _____Relationship: _____Telephone #: _____

Employment Information

Current Employment: □ Employed □ Unemployed □ Homemaker □ Student □ Other
Employer's Company Name: _____Job Title:_____

Presenting problem

What is the presenting problem/chief complaint?_____
When/how did this start?_____
Have you had this or similar conditions in the past? □ Yes □ No
Is this condition getting (circle): Worse Better Same Recurring
Is this pain (circle): Dull Achy Sharp Electrical Throbbing Stiffness Cramps
Rate pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)
Frequency: (Percentage of day symptoms felt) 0%-25% 26%-50% 51%-75% 76%-100%
Any (circle): Numbness / Tingling / Weakness / Changes in Bowel or Bladder habits/ Head Ache / Nausea / Pain with Sneezing, Coughing, Straining / Dizziness / Fever / Fatigue
How does this condition interfere with your daily routine? _____
What aggravates your condition? _____
What relieves your condition? _____
Types of previous treatment and/or surgery for this condition? _____

Personal Health History

Medications, including over the counter, you currently take:_____
_____
Allergies: _____
Vitamins/Supplements you currently take: _____
List any serious illness you have had: _____
Date of last physical examination: _____ Please list any abnormal findings:_____
_____
Surgeries:_____
Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind? _____
Family health history: describe any conditions/diseases(i.e. heart disease, diabetes, other inherited diseases) suffered by family members:_____

Please see back for informed consent

Informed Consent

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.

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. 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. It is important that you also 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.

Consent of Professional Services and Release of Information

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 hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care, massage therapy or any clinic services that he/she deems necessary in my case; and further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patients' employer. I authorize Maple Ridge Chiropractic & Massage to contact me through mail, fax, phone, voicemail, and/or text regarding my care.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature:_____ Date:_____