NORTHGLENN CHIROPRACTIC
SPINE & INJURY CENTER

Welcome to Northglenn Chiropractic Spine & Injury Center! We are excited to work together to help you achieve your health goals. Please complete forms to the best of your knowledge and make sure to sign the bottom of each page.

NEW PATIENT INTAKE FORMS

Date: ____/____/____ Phone: _____ Cell / Home Age: _____ Birthday: ____/____/____

Name: _____ Preferred Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____ How Did You Hear About Us? _____

Height: _____ Weight: _____

CONSENT TO TREAT A MINOR *Do not sign if over the age of 18

(I)_____, the undersigned, parent(s)/person having legal custody/legal guardianship of _____ _____, a minor, do hereby authorize and give consent to Northglenn Chiropractic Spine & Injury Center for any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.
This authorization shall remain effective until revoked in writing delivered to Northglenn Chiropractic Spine & Injury Center.

Parent/Guardian Signature_____Date:_____

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, whom should we contact?

Name: _____ Relation to patient: _____

Best Contact Number: _____

MAIN COMPLAINT

Type of pain:

- Dull/Achy
- Sharp/Stab
- Burning
- Numbness/Tingling
- Stiff/Tight

Does your pain radiate or refer to other areas? YES NO
If 'YES' please draw where you pain radiates on diagram

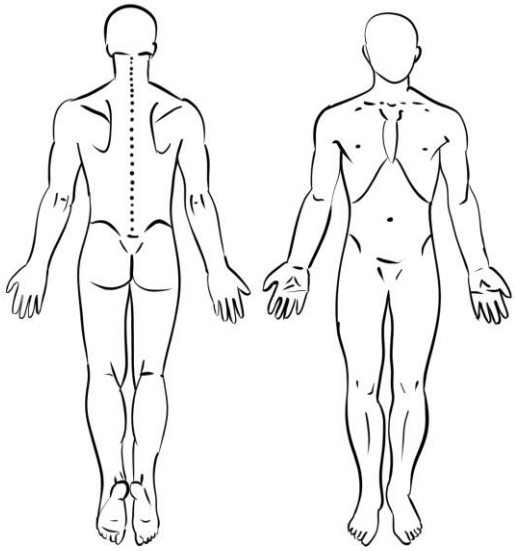
From 1 – 10 how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10

NONE Excruciating

Medical/Surgical Implants:
Medical Alerts: _____ Pregnant: YES NO

Please mark the **ONE** area of your main complaint



Patient Signature_____ Dr. reviewed_____

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PERSONAL HEALTH HISTORY

Please complete the following personal health history section to the best of your ability

MEDICATIONS: (please list ALL medications and supplements that you currently take)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: (please list all medications that cause allergic reactions)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: YES NO If yes, _____Packs per day for _____years

Alcohol: YES NO If yes, number of drinks per week _____

REVIEW OF SYSTEMS

Cervical
- □ Stenosis
- □ Herniated Disc
- □ Degenerative Discs

Lumbar
- □ Stenosis
- □ Herniated Disc
- □ Degenerative Discs

Thoracic
- □ Stenosis
- □ Herniated Disc
- □ Degenerative Discs

Neurological Disorders
- □ Parkinson's
- □ Alzheimer's
- □ Multiple Sclerosis

Foot
- □ Gout R L
- □ Numbness R L
- □ Tingling R L
- □ Burning R L
- □ Drop Foot R L
- □ Pain R L

Leg
- □ Numbness R L
- □ Tingling R L
- □ Burning R L
- □ Pain R L

Hand
- □ Numbness R L
- □ Tingling R L
- □ Burning R L
- □ Pain R L

Cancer
- □ Breast □ Prostate
- □ Intestinal □ Anal
- □ Leukemia
- □ Other: _____
- □ Chemo or Radiation?
- □ Active or Remission?

Arm
- □ Numbness R L
- □ Tingling R L
- □ Burning R L
- □ Pain R L

Heart
- □ Bypass
- □ Congestive Heart Failure
- □ Blood Thinners
- □ High Blood Pressure
- □ Pacemaker
- □ Defibrillator
- □ Stents
- □ Heart Attack
- □ Stroke

FAMILY HISTORY

Please MARK next to any condition that someone in your family HAS or has HAD

- □ Fainting
- □ Scoliosis
- □ Birth Defects
- □ Headaches
- □ Diabetes
- □ Osteoporosis
- □ Heart Attack
- □ High Blood Pressure
- □ Dizziness
- □ Stomach Problem
- □ Cancer
- □ Stroke
- □ Tumor
- □ Aneurysm
- □ Seizures
- □ Allergies
- □ Memory Lapse
- □ Bone diseases
- □ Digestive Problems
- □ Arthritis _____

Patient Signature_____ Dr. reviewed_____

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Informed Consent to Care

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:

Dr. reviewed_____

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Declaration of Agreement Regarding Missed or Cancelled Appointments

Please understand that when an appointment is scheduled for you, a time is set aside and reserved for you on the master schedule. Failure to cancel without appropriate notice prevents us from filling the vacancies on our schedule and often prevents people in need from receiving desired services in a timely manner. Therefore:

1. It is my responsibility to notify two **(2)** hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.
2. I will be charged $25.00 in the event that I miss an appointment and fail to cancel two **(2)** hours prior to the scheduled appointment.

Patient initials _____

Consent for Medical Records Release

This is a confidential record of your medical history and pertinent personal information. Per confirmed consent the doctor will have the ability to discuss medical information with the patient's other doctors upon request. **Copies of this record can only be released by your written authorization.**

Patient initials_____

Patient Signature_____ Dr. reviewed_____