



Confidential Patient Information

Name _____ Hm. Phone _____ Work Phone _____

Address _____ City _____ Postal Code _____

Mailing Address(if different) _____ City _____ Postal Code _____

Email Address _____

Date of Birth _____ Marital Status (circle one) M S D W

Occupation _____ Employer _____

Work Address _____

Emergency Contact Name _____ Phone Number _____

How did you hear about our office? _____

Have you ever had Chiropractic before? YES NO Date _____

Is your injury or illness related to Employment Auto

Location _____ Date _____

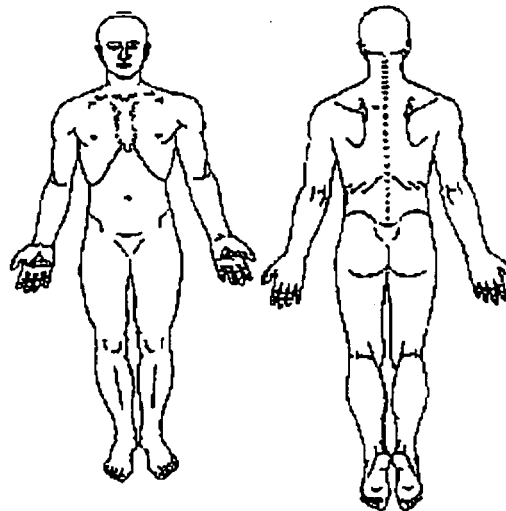
Personal Health Care Number _____

Use letters below to indicate type and location of discomfort

A = Ache	B = Burning	C = Stabbing
N = Numbing	P = Pins & needles	O = Other

List your main complaint in order of severity.

1. _____
2. _____
3. _____



List other Chiropractic or Medical doctors you have consulted for these conditions.

Please list any past surgeries or injuries.

Please list any medications (herbal), vitamins, and minerals that you are currently taking.

Check any of the following you have had in the last 6 months:

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus congestion/Allergies | <input type="checkbox"/> Frequent Nausea/Vomiting |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor/Excessive appetite |
| <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Painful/Excessive Urination |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Prostate/Sexual Dysfunction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other _____ | |

Are you pregnant Yes No Not Sure

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reports association because a stroke may cause serious neurological impairment or even death. The possibility of such occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors or chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss with Dr. Ryan Harris D.C., the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the Chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Print Name _____

Date: _____

Patient

Signature _____

(or legal guardian)