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NEW PATIENT QUESTIONNAIRE

Name:_____ Nickname_____ DOB _____

Address:_____ Gender _____

Phone:_____ Email:_____ Marital Status: S / M / D / W / P Height:_____ Weight:____

Emergency Contact:_____ Phone:_____ Relationship _____

Primary Care Physician:_____ Referred by:_____

Primary Language:_____ Employer:_____ Occupation:_____

Allergies:_____

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past

Osteoarthritis/Degenerative Joint disease _____

Asthma _____

Diabetes Type I _____ Type II _____

Cancer _____ Type _____

Rheumatoid Arthritis _____

Depression/Anxiety _____

Disc Herniation: neck ____ mid-back ____ lower back ____

High blood pressure _____

Heart disease/Stroke _____

Whiplash injury _____ Date _____

Headaches _____ Migraines _____

Joint Pain: Shoulder L / R; Hip L / R; Knee L / R

Other:_____

Osteopenia/Osteoporosis _____

Fibromyalgia _____

Currently pregnant: Yes___ No___ If yes, # of weeks____

Fractures:_____

_____

Surgeries:_____

_____

FAMILY HISTORY: Please check ALL of the conditions that run in your family.

Cancer: Type: _____

Diabetes Type I _____ Type II _____

Heart Problems/ Stroke _____

High Blood Pressure_____

Rheumatoid Arthritis_____

Other:_____

_____

_____

List of your current medications	

List of your vitamins & supplements	

PLEASE DESCRIBE YOUR SYMPTOMS

Complaint #1: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Complaint #2: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Complaint #3: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

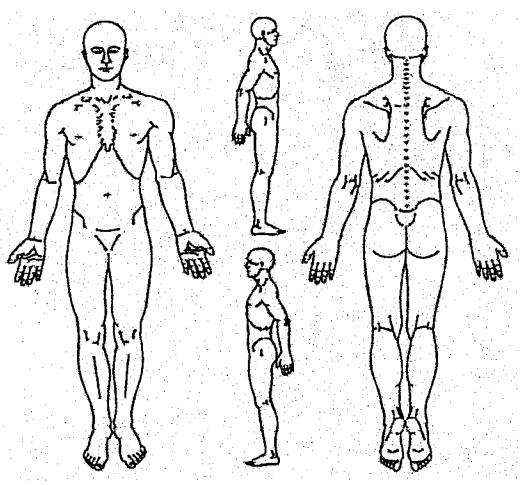
What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Other Complaints: _____

Please indicate on the diagram where you have pain or other symptoms:



Name: _____ Date:_____

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination and treatment, you are consenting to the following procedures:

Spinal manipulative therapy, Orthopedic testing, Basic neurologic testing, Palpation, EMS, Ultrasound, Hot/cold therapy, Traction, Decompression.

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to disc injuries, fractures and muscle strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some people will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:

Fractures are extremely rare occurrences and generally result from some underlying weakness of the bone which I check for during the examination process. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million to one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include: (1) Self-administered, OTC analgesics and rest, (2) Medical care and prescription drugs, (3) Hospitalization, (4) Surgery. If you choose to use one of these options you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary medical physician.

I have read _____ or have had read to me _____ the above explanation of the chiropractic adjustment and related treatment. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at CPG responsible for any errors or omissions that I may have made in the completion of this form. By signing this form, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent for treatment.

I understand that I am liable for all charges for services rendered and I agree to notify the practitioner immediately whenever I have changes in my health condition or health plan coverage on the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.

Patient Signature:_____ Date:_____

Massage Therapy Informed Consent

By signing below, the patient agrees to the following:

1. Massage Therapy has been recommeneded to me as a part of my treatment plan and that it is my chioce to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage

2. All massage treatments, information, and records will be kept confidential and securely stored for use only by the massage therapist and the chiropractor.

3. Written concesnt must be given by me prior to any disclosure or sharing of my personal and clinical information with any third party.

4. Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of treatment.

5. Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.

6. If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to immediately terminate the session or request modifications to the treatment, regardless of any prior consent given.

7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so that he/she may adjust accordingly

8. I understand that while performing the massage, the therapist will maintain a professional distance from sensitive areas of my body. If my condition requires massage therapy in proximity to a sensitive area, this will be discussed with me and my permission will be obtained before working in proximity to these areas.

9. I understand that based on my personal preference, I have the right to request wither a male or female therapist. If I do not specifically request a male or female massage therapist, I may receive a massage from wither, depending on my appointment time.

I,_____(**PRINT NAME**) have read and understand the information above and consent to receiving massage therapy.

PATINET SIGNATURE:_____**DATE:**_____

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