HALSEY CHIROPRACTIC & ACUPUNCTURE **PATIENT INFORMATION**

Date: ____________________

Name: ____________________________________

Address: __________________________________

City: ______________ State: _____ Zip: ________

Cell Phone: ___________________________

E-Mail: _____________________________________

Age: ________ DOB: _________________________

Sex ☐ M ☐ F

☐ Single ☐ Married ☐ Partnered ☐ Minor

☐ Separated ☐ Divorced ☐ Widowed

Who may we thank for referring you? _______________

Employer/School __________________________________

Occupation ______________________________________

IN CASE OF EMERGENCY, CONTACT

Name ____

Relationship _____________________________________

Contact Number ___________________________________

Date of last Physical Examination _____________________

Have you seen a Chiropractor before? ☐ Y ☐ N

Have you had Acupuncture before? ☐ ☐

Treatment you are here for:

☐ Chiropractic ☐ Acupuncture ☐ Both

HOW CAN WE HELP YOU?

What brings you in today? ____

Date symptoms appeared or accident happened: ______________ Have you had same/similar condition? ☐ Y ☐ N

Is this due to ☐ Auto ☐ Work ☐ Other ____

Have you had any major illnesses, injuries, falls, auto accidents? ____

Do you have a history of stroke or hypertension? ____

Have you had any spinal surgeries? ____

Have you been treated for any major health condition by a physician in the last year? ☐ Yes ☐ No
If yes, describe: ____

Women are you pregnant? ☐ Yes ☐ No

Are you having difficulty getting pregnant? If yes please explain: ____

INSURANCE

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

Have you had or do you now have any of the following symptoms/conditions?

- ◊ Headaches
- ◊ Stiff Neck
- ◊ Back Pain
- ◊ Muscle Spasms
- ◊ Shoulder/Neck/Arm Pain
- ◊ Hip Issues
- ◊ Numbness
- ◊ Stroke
- ◊ Sleeping Problems
- ◊ Dizziness
- ◊ High Blood Pressure
- ◊ Weakness in Extremities
- ◊ Broken Bones
- ◊ Reproductive Issues
- ◊ Indigestion Problems
- ◊ Loss of Balance
- ◊ Diabetes
- ◊ Seizures/Epilepsy
- ◊ Pacemaker
- ◊ Osteoporosis
- ◊ Rheumatoid Arthritis
- ◊ Cancer

What does it feel like? (check where appropriate)

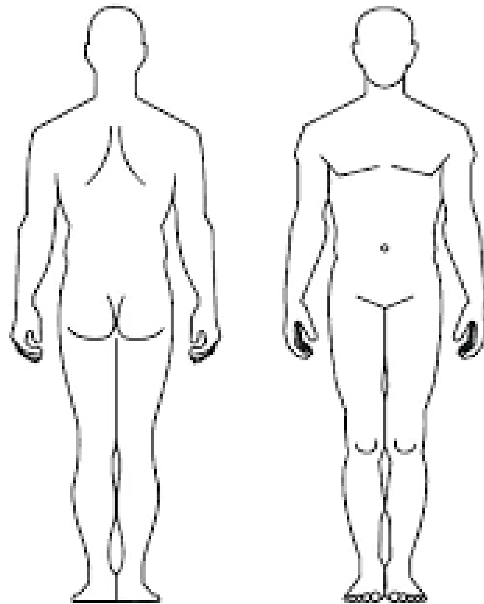
- ◊ Numbness
- ◊ Tingling
- ◊ Stiffness
- ◊ Dull
- ◊ Aching
- ◊ Cramping
- ◊ Nagging
- ◊ Sharp
- ◊ Shooting
- ◊ Burning
- ◊ Throbbing
- ◊ Stabbing
- ◊ Swelling
- ◊ Other ______________

How bad is it? How intense are your symptoms?

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

NO SYMPTOMS — INTENSE SYMPTOMS

Place a X where you have pain or other symptoms:



DOCTORS NOTES:

Cervical____

____

Thoracic____

____

Lumbar____

____

Extremities____

____

◊ Stim

____

____

◊ ACU

____

____

◊ CMT

____

____

Informed Consent to Initiate Acupuncture Treatment
HALSEY CHIROPRACTIC & ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by Dr. Douglas Halsey.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some side effects including mild pain, bruising, numbness or tingling near the needling sites that may last a few days. Unusual risks include nerve damage and infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment. While generally safe for pregnancy, some acupuncture points are contraindicated so if you are pregnant, please tell me when I take your clinical history.

I understand that the clinical and administrative staff may review my patient records but all my records will be kept confidential and will not be released without my written consent. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment in this office.

______________________________________ _______________

Printed Name Date

____

Patient Signature

____

Signature of Parent or Guardian (if a minor)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

To the patient: 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 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 will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That 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 a part of the analysis, examination, and treatment, you are consenting to the following procedures if necessary:

- ◊ Spinal Manipulation
- ◊ Palpation
- ◊ Range of Motion Testing
- ◊ Orthopedic Testing
- ◊ Basic Neurological Test
- ◊ Muscle Strength Test
- ◊ Postural Analysis Test
- ◊ Hot/Cold Therapy
- ◊ EMS
- ◊ Radiographic Studies
- ◊ Myofascial Release

The Material Risks Inherent in Chiropractic Adjustment
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: fractures, disc injuries, dislocations muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. 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 rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. 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 and 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:
*Self-administered, over-the-counter analgesics and rest *Hospitalization *Surgery
*Medical care and prescription drugs, such as anti-inflammatory, muscle relaxants, and pain-killers
If you chose to use one of the above noted "other treatments" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with [Dr. Douglas Halsey] and have had my questions answered to my satisfaction. By signing below 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 herby give my consent to that treatment.

____ __________________
Printed Name Date

____
Patient Signature

____
Signature of Parent or Guardian (if a minor)