APPLICATION FOR TREATMENT

Name_____Today's Date _____

Address: _____

Birthdate:_____ Are you pregnant? ☐ Yes ☐ No Social Security #:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Employer's Name & Address: _____

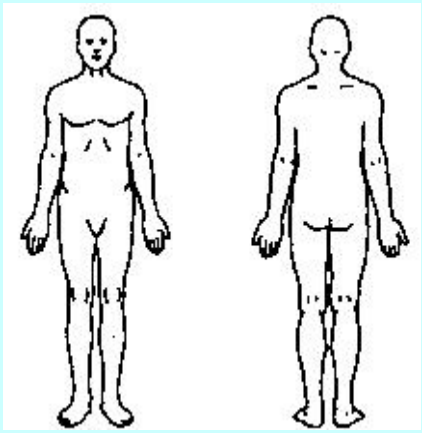
Occupation:_____Work Phone_____Home Phone _____

Email Address_____ Cell Phone _____

How did you hear about us? _____

What type of care do you desire? ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in correcting:

1._____

2._____

3. _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.:

1._____

2._____

3._____

When was the first time you noticed this problem? _____

_____

Describe any accidents, falls, injuries, sudden movements, etc., that may have caused your problem: _____

_____

Have you had any similar health problems or injuries before? ☐ Yes ☐ No If yes, please explain:_____

_____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results): _____

_____

_____

Has your health problem has been: ☐ Improving ☐ Worsening ☐ Staying the same

Please describe anything you do that improves or worsens your condition:_____

_____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

☐ Home activities affected: _____

☐ Work activities affected: _____

Have you missed any work days? How Many? _____

☐ Recreational activities affected: _____

☐ Rest or sleep affected: _____

Have you been treated by a doctor within the last year? _____

If yes, please explain: _____

_____

Name, Address, and Phone Number of Medical Doctor:

_____

_____

Have you ever received Chiropractic care? _____ If yes, please list the doctor's name, address and what your problem was at the time: _____

_____

Please check off the drugs you are now taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory

☐ Blood Pressure Medication ☐ Insulin ☐ Tranquilizers ☐ Diet Pills ☐ Birth Control

☐ Nerve Medication ☐ Anti-Depressants ☐ Other (please list): _____

_____

List the approximate dates of any accidents or serious injuries (including broken bones) you have had: _____

_____

_____

_____

List any surgeries and dates:

_____

_____

_____

If you have been in an auto accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Please check off the following that apply to you within the past 2 years: ☐ Went to a Health Spa

☐ Purchased Vitamins ☐ Purchased Health Foods ☐ Received a Massage

Please explain why you choose to do any of the above: _____

_____

Who is responsible for your bill? ☐ I am ☐ Spouse ☐ My Employer ☐ Insurance

Type of Insurance: ☐ Worker's Comp. ☐ Health ☐ Automobile

Insurance Company's name and address: _____

_____

**Your fees are due and payable at the time examination and treatments are received, unless other arrangements have been made in advance.*

I, the undersigned, hereby give permission for treatment.

Patient's
Signature: _____ Date: _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough

Confidential Patient Case History

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others:

_____

_____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe:

_____

_____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: *NAME* _____ *Relationship:* _____

ADDRESS: _____ *PHONE:* _____

Informed Consent Document

PATIENT NAME: _____

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:

*Spinal manipulative therapy	*Palpation	*Vital signs
*Range of motion testing	*Orthopedic testing	*Basic neurological examination
*Muscle strength testing	*Postural analysis testing	*Graston/IASTM
*Cold laser therapy	*Hot/Cold therapy	
*Radiographic studies	*Cupping	

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 injuries to the arteries in the neck leading to or contributing to serious complications including 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
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" 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.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. 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 hereby give my consent to that treatment.

_____ **Dr. Chitra Rajendran, DC**

Patient's Name **Date** **Doctor's Name** **Date**

_____ _____

Signature **Dr. Chitra Rajendran Signature**

_____

Signature of Parent or Guardian
(if a minor)