# APPLICATION FOR TREATMENT

Name_____Today's Date_____

Address: _____

Birthdate:_____ Are you pregnant? ☐ Yes ☐ No

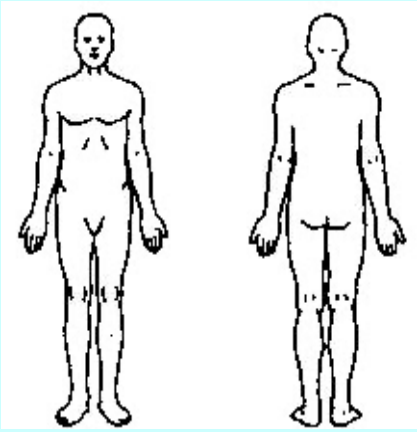
Employer's Name & Address: _____

Occupation:_____Work Phone_____Home Phone _____

Email Address _____ Cell Phone_____

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._____

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 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, operations or serious injuries (including broken bones) you have had: _____

_____

_____

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: _____

_____

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

Names and Ages of Children_____

Name of Spouse_____

Spouse's Employer_____Work Phone_____

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:_____

_____

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

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_____ Social Security No:_____ Date_____

# 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 testing |
| *muscle strength testing | *postural analysis | |
| *ultrasound | *hot/cold therapy | *Electric Muscle Stimulation |
| *radiographic studies | *Inter Segmental Traction | |

**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.**

**Dated:_____** **Dated:_____**

_____ **Dr. Chitra Rajendran**

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

_____ _____

**Signature** **Dr. Chitra Rajendran Signature**

_____

**Signature of Parent or Guardian**
**(if a minor)**