Welcome to Wilks Chiropractic

Confidential Health Questionnaire

Name _____ **Date** _____
Address _____

_____

Home Phone: _____ **Cell:** _____ **Work:** _____
Email: _____(for appointment confirmation)
Emergency Contact: _____ **Phone** _____
Sex: ☐ M ☐ F **Age** ____ **Date of Birth** _____ **SSN** _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Occupation_____ Full Time or Part Time?
Employer_____ Retired from:_____
General Physician: _____
Permission to consult with them if necessary Y N
Prior Chiropractic Care? Dr_____ Last date seen _____

Who may we thank for referring you? _____
We are proud to say 95% of our patients are referred!

Circle 1-10 severity of pain and shade problem areas on figures to the right
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Case Type:
___ Personal Health Insurance
___ Medicare ___ Auto Accident
___ Workers Comp ___ Self Pay

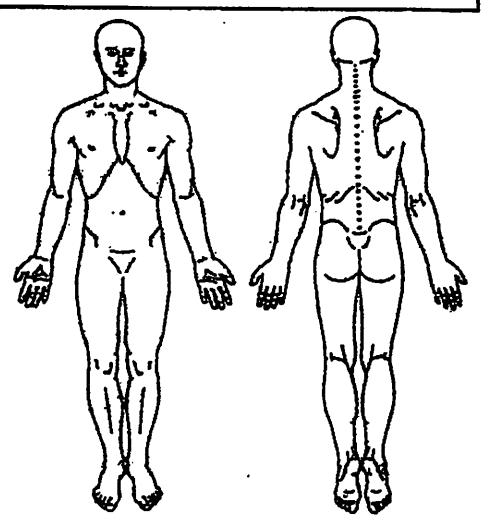
Insured's Name (if not you)
_____
Insured's Date of Birth _____

If condition is due to an accident, please list responsible contact persons:
_____
Phone _____

*** Please present any insurance cards, auto accident, worker's comp. or attorney info to receptionist**

Tell us why you're here today:

Chief Complaint: _____
Complaint #2: _____
Complaint #3: _____
When it started: _____
What caused or aggravated it: _____
Is it changing? ☐ Worse ☐ Same ☐ Better
Have you had this condition before? ☐ Yes ☐ No: When? _____
How often do you have the symptoms? ☐ Constant (75-100% of day)
☐ Frequent (50-75% of day)
☐ Intermittent (25-50% of day)
☐ Occasional (> 25% of day)



Describe the discomfort: ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Numbness
☐ Sharp ☐ Shooting ☐ Stiffness ☐ Swelling ☐ Throbbing ☐ Tingling
Other:_____

Any pain, numbness, tingling, or weakness radiating to the arms? ☐ No ☐ Left ☐ Right ☐ Both
legs? ☐ No ☐ Left ☐ Right ☐ Both

Treatments attempted for condition? ☐ None ☐ Acupuncture ☐ Anti-inflammatories ☐ Chiropractic ☐ Heat ☐ Ice ☐ MRI
☐ Muscle Relaxers ☐ Nerve Block ☐ OTC Meds ☐ Physical Therapy ☐ Pain Medications ☐ Surgery ☐ Topical Ointments
Other Doctors seen: (treatment, tests, results) _____
What makes it better? _____
What makes it worse? _____ **Worse to cough or sneeze?** Yes or No

List the 3 most affected activities that you are unable to do or are having difficulty with as a result of your complaint:
(be specific: work activities, taking meds to get through, hobbies, sleeping, personal care, household chores, etc.)

1. _____ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform
2. _____ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform
3. _____ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

Family History

(Please tell us **which** of your immediate family members have had any of the following diseases.)

Cancer (what type?) _____
Diabetes (type 1 or type 2?) _____
Arthritis (Rheumatoid or Osteoarthritis?) _____
Heart Disease _____

Adopted _____
Died under the age of 50 _____
Other _____

Personal Health History

Please note any conditions or problems you currently have or have had.

General	☐ Cancer: (what type) _____				☐ Unexplained weight loss
	☐ HIV	☐ Fatigue-weak	☐ Chronic fever	☐ Night sweats	☐ Chronic infections
EENT	☐ Allergy-Sinus	☐ Vertigo	☐ Vision	☐ Hearing	☐ Speech
MS	☐ Neck pain	☐ Mid back	☐ Low back pain	☐ Osteoporosis	☐ Arthritis-Rheumatoid
	☐ Scoliosis	☐ Prosthesis	☐ Fibromyalgia	☐ Disc herniations	☐ Plantar Fasciitis
	☐ Dislocations	☐ Fractures (list here: _____)			
CRS	☐ High BP	☐ Heart attack	☐ Blockage/clots	☐ High cholesterol	☐ Anemia
	☐ TB	☐ Breathing	☐ Chronic cough	☐ Heart surgery	☐ Vascular surgery
GI	☐ Colon- IBS	☐ Ulcers	☐ Hernia	☐ Appetite-Anorexia	☐ Reflux-GERD
GU	☐ Breast	☐ Abn. periods	☐ Abn. pap smear	☐ Urination problems	☐ Pregnant
	☐ Kidney	☐ Prostate	☐ Testicular	☐ Bladder	☐ Sexual Dysfunction
CNS/PNS	☐ Headache	☐ Seizures	☐ Fainting	☐ Dizziness/Balance	☐ Epilepsy
	☐ Neuropathy	☐ Paralysis	☐ Memory	☐ Parkinson's	☐ Multiple Sclerosis
Endocrine	☐ Diabetes I, II	☐ Thyroid	☐ Liver	☐ Hepatitis A, B, C	☐ Excess thirst-urine-sweat
Vascular	☐ Stroke	☐ Clots	☐ Bleeding disorder	☐ Lymph edema	☐ Extremity coldness
Psych	☐ Anxiety	☐ Depression	☐ Insomnia	☐ Suicidal	☐ Psych counseling-meds
Skin	☐ Rash	☐ Itching	☐ Sores	☐ Excess bruising	☐ Skin Cancer

Please list ANY significant accident, surgery, or test no matter how long ago. It could relate to your present complaints.

Approximate Dates

Surgeries _____ _____
Significant Falls or Trauma _____ _____
Extended hospital stays _____ _____
MRI, CT, Bone scans & results _____ _____
Motor Vehicle Accidents _____ _____

Tobacco/Vape? Y or N If yes, ☐ 1/2 pack-day ☐ 1 pack-day ☐ 1-2 pack-day ☐ Oral tobacco ☐ Vape
Do you drink: (circle and fill out all that apply) **Alcohol?** If yes, how many drinks ___ /day or ___/ week
Coffee Tea Sodas? ___/day or ___/week
High Stress due to: ☐ Career ☐ Family ☐ Marriage ☐ Relationship ☐ Drug abuse
Sleep habits : ☐ Hours (Side – back – stomach –all over) (Good -- fair – restless leg syndrome-- insomnia)
Medications/ Supplements

☐ None	☐ OTC	☐ Pain meds	☐ Muscle relaxer	☐ Anti-inflammatory
☐ Heart	☐ HBP	☐ Blood thinner(s)	☐ Cholesterol	☐ Thyroid
☐ Hormones	☐ Birth control	☐ Anti-depressant	☐ Multivitamin	☐ Calcium
☐ Magnesium	☐ Fish Oil	☐ Glucosamine	☐ Other:_____	

Other Hobbies/Activities: (such as golf, fishing, hunting, taking care of elderly parent, etc.)
Caregiving: _____ Hobbies: _____
Sports: _____ Volunteering: _____
Yardwork: _____ Housework: _____

Exercise (mark all that apply) ☐ None ☐ Minimal ☐ Moderate or ☐ Daily If exercise, low or high intensity?
☐ Aerobics ☐ Weights ☐ Yoga ☐ Other Specify:_____

Patient or guardian signature_____ **Date** _____

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

- o physical examination
- o ultrasound therapy
- o laser therapy
- o palpation
- o postural analysis
- o hot/cold therapy
- o traction/decompression
- o rehabilitation
- o vital signs
- o diagnostic studies
- o electrical muscle stimulation
- o bracing and support applications
- o manual therapy
- o acupuncture/dry needling

The material risks associated with chiropractic treatment

Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. 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 may include the following

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Dr. Wilks will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. Wilks does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.

Patient:

I [ ] have read, or [ ] have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize~~,~~ Dr. Wilks and his/her assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. Wilks and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits 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.

Patient's Name _____ Patient's Signature _____

Date _____ Signature of Parent/Guardian (if patient is a minor) _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a decrease of the body's ability to express maximum health and function.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate physical irritations from your spinal nervous system. Our only method is specific adjusting to correct vertebral subluxations.

I, X_____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian's Signature X_____Date:_____

PATIENT AND DOCTOR AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wilks Chiropractic will prepare all necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Wilks Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize Dr. Wilks to treat my condition, as he deems appropriate through adjusting my spinal column. I understand and agree that the amount paid to Wilks Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of Wilks Chiropractic, being on file where they may be seen by me at any time while I am a patient of this office. I also agree that I am responsible for all bills incurred at this office. Dr. Wilks will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient/Guardian's Signature: X_____Date: _____