

CHIROPRACTIC EXAM

DATE: _____

Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Wk: _____ Cell: _____

DOB: _____

E-Mail: _____

Social Security Number: _____

Occupation: _____

Employer Name & Address: _____

Referred By: _____

	L Reading	R Reading
Head Rotation:		
Ear High On:		
Shoulder High On:		
Ilium High On:		

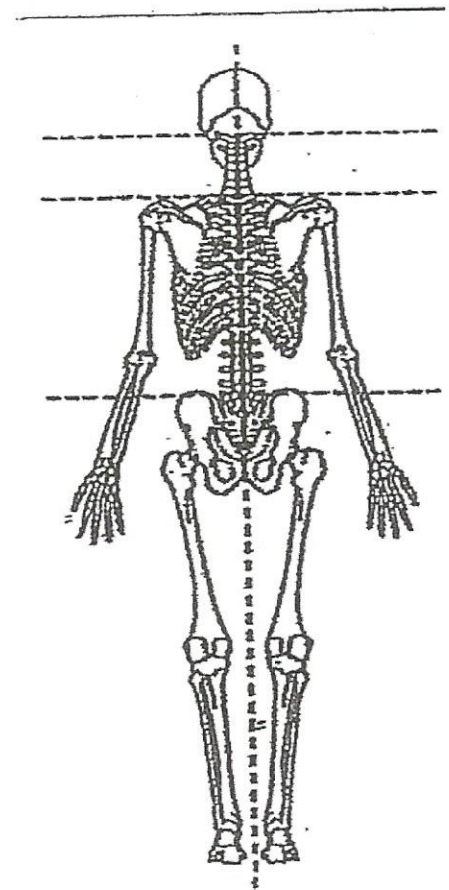
Leg Check R L N P Derifield	L R Cervical Syndrome
Modified Prill (Contracture Leg Id)	Balanced 5 Ways Y N

Vertical Test:		Radial Test:	
Medial Test:		Lateral Test:	

Dual Scale Distribution and Height and Weight

Height:		Weight:	
Weight L:		Weight R:	

Weight Difference L R +



BP: _____

Temperature: _____

PATIENT HISTORY

Name: _____ Date: _____
 All information given in this questionnaire will remain strictly confidential and will only be divulged if you give your written consent.

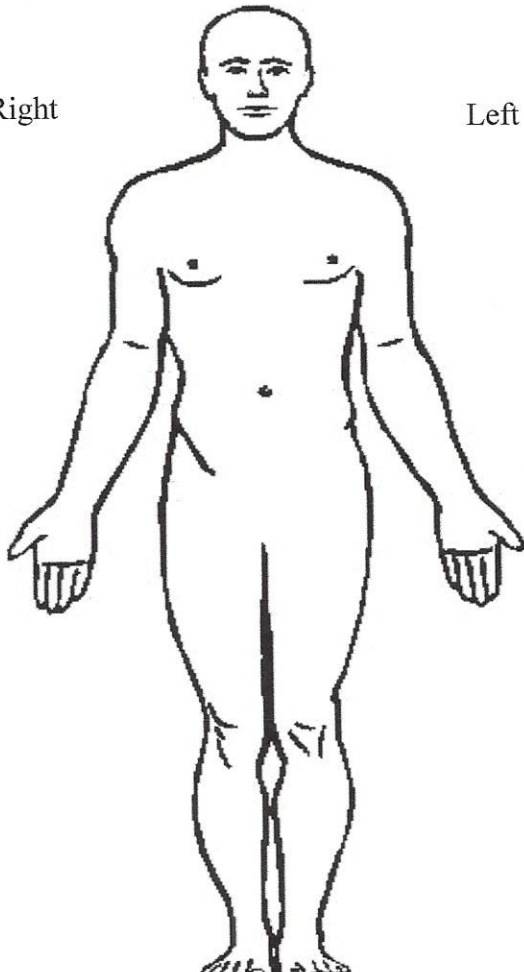
Circle arm dominance: left-handed right-handed

Circle those you suffer from (no matter how slight or infrequent):

- | | | | |
|-----------------------|--------------------------|------------------|------------------|
| FATIGUE | SHOULDER/UPPER BACK PAIN | ANEMIA | LIVER PROBLEMS |
| DIZZINESS | MID BACK PAIN | HIGH CHOLESTEROL | THYROID DISORDER |
| DIGESTIVE PROBLEMS | LOW BACK PAIN | CANCER | STROKE OR TIA |
| DEPRESSION | HIGH BLOOD PRESSURE | DIABETES | ASTHMA |
| SENSORY DEFICITS | SURGICAL IMPLANTS | EPILEPSY | ALLERGIES |
| INSOMNIA | FREQUENT ILLNESS | SEIZURES | PACEMAKER |
| STRESS | POOR CONCENTRATION | HEART DISEASE | URINARY PROBLEMS |
| HEADACHES | PAINFUL MENSTRUATION | GALLBLADDER | KIDNEY DISEASE |
| NECK STIFFNESS / PAIN | MUSCLE / JOINT PAIN | ULCERS | HIV POSITIVE |
| ANXIETY | SUDDEN WEIGHT CHANGE | SKIN PROBLEMS | TMJ |
| SINUS PROBLEMS | LUNG DISEASE | ACID REFLUX | STOMACH PAIN |
| SPLEEN ISSUES | PANCREAS PROBLEMS | FOOT PAIN | LEG PAIN |

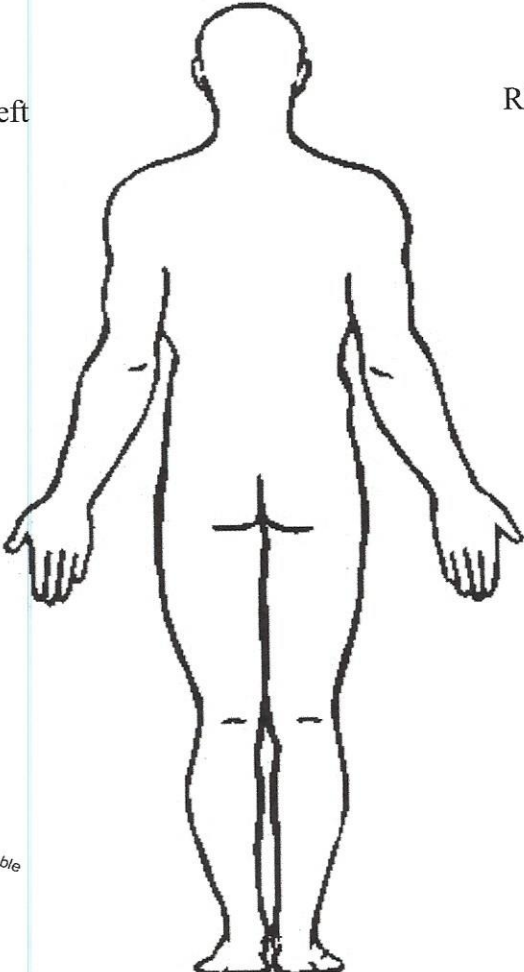
Place an "X" where there is pain; Rate that pain on a scale of 1-10 (10 being severe); place an "N" where you have numbness; place an "S" where you have scars from injuries or surgeries and create a line for the scar pattern; Place an "M" where you have moles; place an "F" where you have had fractures.

Right



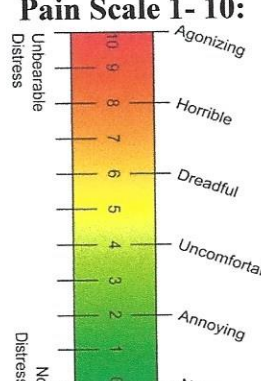
Left

Left



Right

Pain Scale 1- 10:



PATIENT HISTORY

Patient Name: _____

Date: _____

Please list any accidents, falls, traumas of any kind, since childhood

NONE

Car Accident, Trauma Or Fall? Date: Did You Lose Consciousness? Taken to Hospital? Diagnosis / Result

Car Accident, Trauma Or Fall?	Date:	Did You Lose Consciousness?	Taken to Hospital?	Diagnosis / Result

Please List Any Surgeries or Hospitalizations

NONE

Date	Surgery	Date	Hospitalization

Please List Any Allergies to Medication, Foods or Other Substances along with the reaction you have

NONE

Allergy	Reaction	Allergy	Reaction

Please list any medications that you have been prescribed.

NONE
Prescribing Doctor

Medication	Dosage	Reason	Date Prescribed	Still Taking?	Prescribing Doctor

Please list any Herbs, Vitamins, Supplements you are taking.

NONE

Name	Dosage	Reason	Date You Started Taking	Still Taking?	Recommended by?

PATIENT HISTORY

Patient Name: _____

Date: _____

Other Health Issues: _____

Other Symptoms: _____

Reason for this visit: _____

When did this start? _____ How did it begin? _____

Has it happened before? _____ If yes, when? _____

What concerns you most about this problem? _____

What does it prevent you from doing? _____

Have you had any previous chiropractic care? _____

What forms of exercise do you enjoy? _____

How often do you exercise? _____ How long do you exercise? _____

How many hours do you sleep each night? _____ How do you feel when you wake up? _____

What position is most comfortable for you to sleep? _____

How would you describe your stress level? (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your diet? (Please circle all that apply)

EXCELLENT

PRETTY GOOD

GOOD ENOUGH

JUST OKAY

**COULD BE A LITTLE
BETTER**

**COUD BE A LOT
BETTER**

TERRIBLE

I NEED HELP

How would you rate your overall health? (worst) 0 1 2 3 4 5 6 7 8 9 10 (best)

I hereby acknowledge that the statements and answers given on this form are accurate to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health. Furthermore, I hereby agree to allow this office to examine and further evaluate me.

Patient Signature _____ Date _____

Straight Chiropractic

James P. Fiore, D.C.

714 543 2430

Terms of Acceptance – Goals of Chiropractic

When a person seeks Chiropractic care, and when a Chiropractor accepts a person for such care, it is essential that they both be seeking and working towards the same goal.

This office has only one goal - to keep the body as free as we can from vertebral subluxations. It is, therefore, important that everyone understands that goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding or disappointment.

People usually want to get rid of whatever ailments or conditions may be bothering them. However worthy such a goal may be, it is not the goal of this office. We do not engage in the medical practice of diagnosing, treating or advising about disease.

Chiropractic care should not be done with the intention of treating or curing any disease conditions, but with the conviction that every human being functions better on all levels when no vertebral subluxations are present.

We do not offer any diagnosis, treatment or advice about disease conditions.

I, _____, undertake Chiropractic care in this office with the understanding and agreement with the above terms of acceptance and goals of Chiropractic.

Signature

Date

Informed Consent Form – Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common^{1,2}

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours.

Rare^{3,4}

- Fractures of joint injuries in isolated cases with underlying physical defects, deformities or pathologies.
- Physiotherapy burns due to some therapies.
- Disc herniations
- Cauda Equina Syndrome⁽²⁾ (1 case per 100 million adjustments).
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headaches or neck pain that is the worst you have ever felt⁽³⁾.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and a referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks.
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery⁵.
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation and worsening of my condition⁶.

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine; a prospective national survey. *Spine*. Oct 1, 2007; 32(21): 2375-2378; discussion 2379.
2. Rubinstein SM, LeboEUF-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther*. Jul-Aug 2007; 30(60): 408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar artery stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*. Feb 15 2008; 33(4 Suppl): S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine*. Feb 15 2008; 33(4 Suppl) S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008; 33(4 Suppl): S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008; 33(4 Suppl): S75-82.

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	NO	DOCTOR'S COMMENTS
GENERAL			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	
BONE WEAKNESS			
Have you been diagnosed with osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take corticosteroids (e.g. prednisone)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed with a compression fracture(s) of the spine?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have metal implants?	<input type="checkbox"/>	<input type="checkbox"/>	
VASCULAR WEAKNESS			
Do you take aspirin or other medication on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, about how much do you take daily? _____			
Do you take warfarin (Coumadin), heparin, or other similar "blood thinners"?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed with any of the following disorders/ diseases?			
• Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
• Giant cell arteritis (temporal arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	
• Osteogenesis imperfecta	<input type="checkbox"/>	<input type="checkbox"/>	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
• Medical cystic necrosis (cystic mucoid degeneration)	<input type="checkbox"/>	<input type="checkbox"/>	
• Bechet's disease	<input type="checkbox"/>	<input type="checkbox"/>	
• Fibromuscular dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever become dizzy or lost consciousness when turning your head?	<input type="checkbox"/>	<input type="checkbox"/>	
SPINAL COMPROMISE OR INSTABILITY			
Have you had spinal surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, when? _____			
Have you been diagnosed with spinal stenosis?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been diagnosed with spondyliolithesis?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any of the following problems?	<input type="checkbox"/>	<input type="checkbox"/>	
• Sudden weakness in the arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	
• Numbness in the genital area?	<input type="checkbox"/>	<input type="checkbox"/>	
• Recent inability to urinate or lack of control when urinating?	<input type="checkbox"/>	<input type="checkbox"/>	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [OR parent/guardian] SIGNATURE _____ DATE _____

INTERN'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____

Straight Chiropractic

B. J. Palmer – W. G. Blair
Specific Upper and Lower
Cervical Articular Adjustments

James P. Fiore, D.C.
714 543 2430

JAMES P. FIORE, D.C.

ACCEPTS THE FOLLOWING FORMS OF PAYMENT:

- CASH
- CREDIT CARD (Visa, MC, Discover, AmEx)
- CHECK (payable to James Fiore)

This clinic's policy is that **payment is due at time of treatment**. We **DO NOT** accept ANY insurance at all, including Medicare, as payment for chiropractic services rendered in this clinic. **DO NOT BILL MEDICARE FOR OUR SERVICES. WE ARE NOT A MEDICARE PROVIDER.**

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account.

Please note the following:

- Payment plans can be arranged, at no additional charge, if necessary. Please inquire with the front desk for details.
- Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau. Furthermore, if a past due statement is returned with no forwarding address, you will be charged \$10 and turned over to our collection agency.
- Please be courteous and give a 24-hour advance notice if you are cancelling an appointment so that we may accommodate others in need. **There will be a \$25 charge for missed appointments without the 24 hour notice.**
- By moving forward with care at this clinic, you agree to pay for any and all services you receive from the doctors and ancillary providers of this clinic. In the event you do not pay for these or any other services provided when they are due, you agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a law suit is commenced) as part of the collection process.

By my signature below, I certify to having read the above statements and I fully understand my financial responsibility for *all care rendered to me so long as I am a patient of Straight Chiropractic.*

Date: _____

(Signature)

(Print Name)

1850 East 17th St. / Suite 120 / Santa Ana, CA 92705