



SCHROEDER FAMILY CHIROPRACTIC

421 E 30th Ave. | Hutchinson, KS 67502 | 620.663.2678

www.schroederfamilychiro.com

Confidential Patient Information

Personal Information:

Name: _____ Today's Date: _____

Street: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Cell phone: (____) _____

Work phone: (____) _____

Email: _____

What is the best way to contact you? Phone _____ Text _____ Email _____ FB _____

Birth date: _____ Social Security Number: _____

Sex: Male Female

Marital status: Single Married Divorced Widowed

Spouse's/Significant other's name: _____

Number of children: _____ Number of children living with you: _____

Names of children: _____

Name and phone number of nearest friend/relative not living with you: _____

(____) _____

Employer Name: _____ Occupation: _____

Number of drinks per day: Water _____ Caffeine (Soda, Tea, Coffee) _____ Alcohol _____

Do you exercise? _____ How often? _____ times per week for _____ minutes

What type of exercise? _____

Do you feel your weight has affected your symptoms? _____ If yes, how? _____

Have you ever been to a chiropractor before? YES NO

Are your symptoms due to an accident? YES NO

If yes, what type of accident? AUTO WORK OTHER

Date of accident: _____ Accident reported? YES NO Worker's Comp Insurance Carrier Employer

Prior treatment for these problems? _____

Prior treatment as the result of an accident? _____

Are you pregnant or think you are pregnant? YES NO Date of last menstrual period: _____

Who is your primary care physician? _____

Have you recently had:

- Neck Pain Yes No
- Mid Back Pain Yes No
- Low Back Pain Yes No
- Headaches Yes No
- Any Other Pain Yes No

Explain where: _____

Pain Scale:

Please fill out the answers accordingly

Score	Meaning
0	No pain
1-3	Pain that does not require change in activity
4-6	Pain that does require change in activity
7-9	Pain that fully prohibits one or more activities
10	Pain that is unbearable

Frequency of Pain

- A- Constant (never goes away)
- B- Intermittent (relieved with position or rest)
- C- Occasionally (daily or less frequent)
- D- Infrequent (once a week)
- E- Variable (comes and goes)

What time of day is your pain the worst?
Morning, Afternoon, Evening or Nighttime

Neck Pain:

Right Now: ____/10 Best: ____/10 Worst: ____/10
Frequency: ____ Time of Day: _____
What makes the pain better? _____

What makes the pain worse? _____

How long have you had current pain? _____

Mid Back Pain:

Right Now: ____/10 Best: ____/10 Worst: ____/10
Frequency: ____ Time of Day: _____
What makes the pain better? _____

What makes the pain worse? _____

How long have you had current pain? _____

Low Back Pain:

Right Now: ____/10 Best: ____/10 Worst: ____/10
Frequency: ____ Time of Day: _____
What makes the pain better? _____

What makes the pain worse? _____

How long have you had current pain? _____

Headaches:

Right Now: ____/10 Best: ____/10 Worst: ____/10
Frequency: ____ Time of Day: _____
What makes the pain better? _____

What makes the pain worse? _____

How long have you had current pain? _____

Other Pain: Explain Where:

Right Now: ____/10 Best: ____/10 Worst: ____/10
Frequency: ____ Time of Day: _____
What makes the pain better? _____

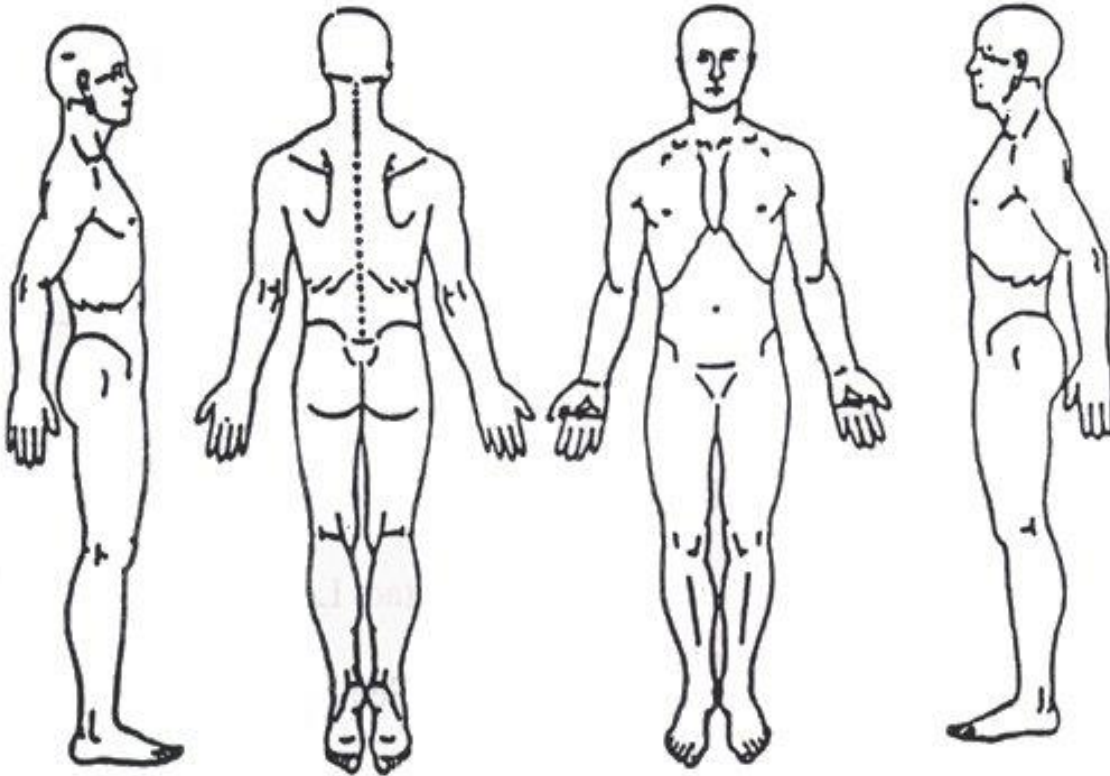
What makes the pain worse? _____

How long have you had current pain? _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	○ ○ ○ ○ ○	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



Activities of Daily Living

Please put the appropriate number that best pertains to you for each of the following questions.

- 0 - I never have problems with this.
- 1 - I have slight pain while performing activities
- 2 - I have moderate pain while performing activities
- 3 - I have severe pain while performing activities
- 4 - I cannot properly perform activity
- 5 - I am unable to perform any of this activity

Do you have difficulties:

- | | | |
|-------------------------|----------------------------|---------------------------|
| ___ 1. Washing | ___ 2. Dressing | ___ 3. Eating |
| ___ 4. Bathing | ___ 5. Brushing your teeth | ___ 6. Brushing your hair |
| ___ 7. Writing | ___ 8. Speaking | ___ 9. Seeing |
| ___ 10. Hearing | ___ 11. Typing | ___ 12. Sitting |
| ___ 13. Standing | ___ 14. Lifting | ___ 15. Walking |
| ___ 16. Climbing stairs | ___ 17. Driving/Riding | ___ 18. Flying |
| ___ 19. Grasping | ___ 20. Sleeping | ___ 21. Group activities |

12. Do you get visual disturbances? _____
If yes, how often? _____

13. Do your ears ring? _____
If yes, how often? _____

14. Do you get dizzy? _____
If yes, how often? _____

15. Is there anything else you are concerned about or feel the Doctor has not addressed? _____



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PREGNANCY RELEASE: INFORMED CONSENT TO X-RAY **(to be completed on day of x-ray)**

PLEASE READ THIS ENTIRE FORM.

All women of childbearing age must sign this release and check any appropriate category.

I have had a hysterectomy or tubal ligation.

I am presently in menopause or post-menopause.

“This is to certify that, to the best of my knowledge, I am not pregnant at this time. I hereby authorize Schroeder Family Chiropractic to take x-rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present.”

Print name: _____

Signature: _____

Date: _____

Witness: _____

INFORMED CONSENT NOT TO X-RAY **(to be completed on day of x-ray)**

I am pregnant.

"This is to certify that, to the best of my knowledge, I am pregnant at this time. I DO NOT authorize Schroeder Family Chiropractic to take x-rays as necessary to determine the status of my spine."

Print Name: _____

Signature: _____

Date: _____

Witness: _____



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Notice of Privacy Practices Acknowledgement Form

Schroeder Family Chiropractic's Notice of Privacy Practices provides information about how we may use and disclose Protected Health information about you. It also provides information on what your rights are regarding your Protected Health Information as outlined by the Health Insurance Portability and Accountability Act of 1996.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by making a request.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices or had the opportunity to review the notice.

(Print Patient Name)

(Patient or Legal Representative Signature) (Date)

(Witness Signature)

(Date)



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Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important 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 used by Doctors 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 | -- ultrasound | -- muscle stim |
| -- muscle strength testing | -- postural analysis | -- hot/cold therapy |
| -- basic neurological testing | -- orthopedic testing | |

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. The Doctor 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 the Doctor’s attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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 chose 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.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Schroeder / Dr. Cullens to perform diagnostic tests and render Chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other Doctors and office staff members and is intended to include radiographic examination at the Doctor’s discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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. Schroeder / Dr. Cullens 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 hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient’s Name

Doctor’s Name

Signature

Signature