SCHRODER FAMILY
WELLNESS CLINIC

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 been treated by a doctor for a health condition in the past year? □ YES □ NO

If yes, please describe: ____

List any medications/vitamins you are currently taking: ____

____

Name of health insurance: ____

Has your deductible been met? □ YES □ NO

Medical History:

□ Anemia	□ Muscular Dystrophy	□ Rheumatic Fever	□ High Blood Pressure	□ Backaches
□ Polio	□ Multiple Sclerosis	□ Scarlet Fever	□ Tuberculosis	□ Cancer
□ Asthma	□ German Measles	□ Nervousness	□ Heart Trouble	□ HIV
□ Epilepsy	□ Concussion	□ Dizziness	□ Digestive Disorder	□ Arthritis
□ Diabetes	□ Sinus Trouble	□ Venereal Disease	□ Hepatitis	□ Neuritis
□ UTIs	□ Convulsions	□ Numbness	□ Rheumatism	□ Fibromyalgia

□ Allergies: Food Allergies ____

Environmental Allergies ____

Family History:

	Diabetes	Heart	Cancer	Back/Neck Pain
Mother	□	□	□	□
Father	□	□	□	□
Brother	□	□	□	□
Sister	□	□	□	□
Grandfather	□	□	□	□
Grandmother	□	□	□	□

Do you experience stomach pains? □ YES □ NO

Do you suffer from either of the following? Constipation □ Diarrhea □ How many bowel movements per day: ______

Have you taken any antibiotics in the past 6 months? □ YES □ NO

Have you had any operations or surgeries? □ YES □ NO If yes, list the date(s) and surgeries(s) performed:

____

List the date(s) of any previous vehicle/motorcycle accidents: ____________________________________

List the date(s) of any previous accidents or falls: ____

List any broken bones/fractures/dislocations and dates: ____

How did you hear about us? □ personal referral, who? ____________________ □ yellow pages thick □ yellow pages thin

□ newspaper ad □ someone called me □ sign □ mailer □ other ___________________

If we are able to help you with your chief complaint, do you know others that could benefit from care?

□ YES □ NO If yes, who?____

I attest that the above information is true to the best of my knowledge.

____

Signature of patient

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? _________________________

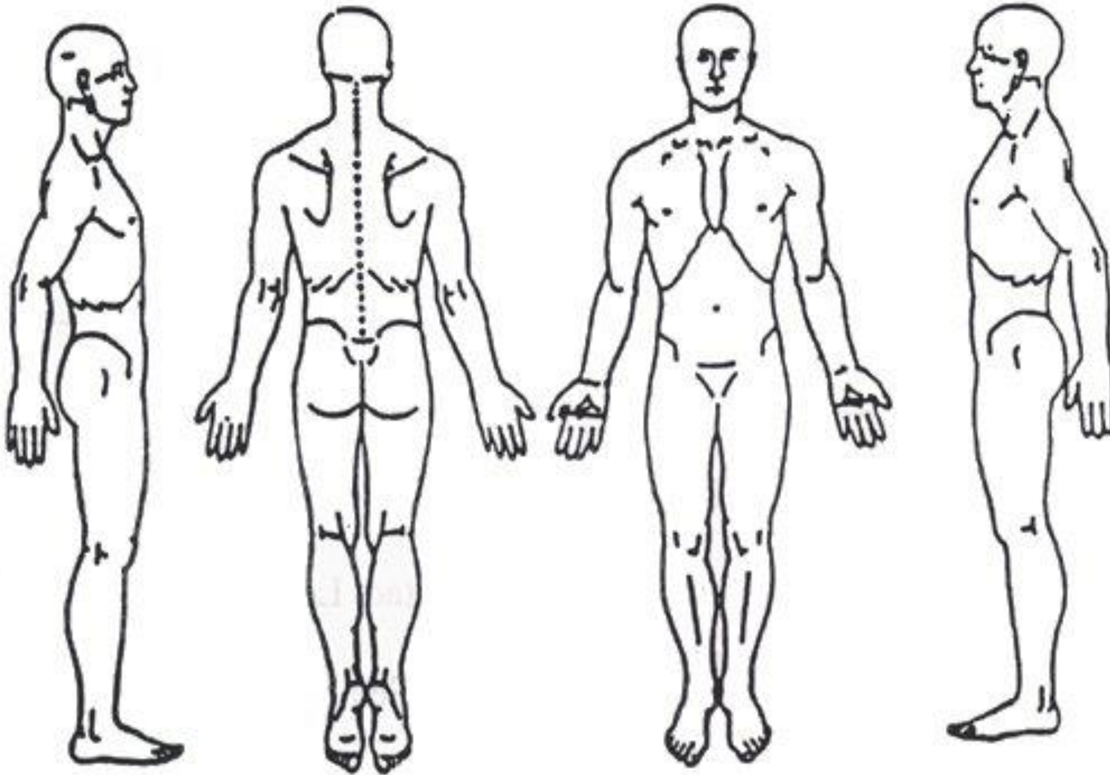
____

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
- - - - - -	o o o o o	^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	**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?____
____
____

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.

o I have had a hysterectomy or tubal ligation.

o 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)

o 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:____

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)

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
-- range of motion
-- muscle strength testing
-- basic neurological testing
-- palpation
-- ultrasound
-- postural analysis
-- orthopedic testing
-- vital signs
-- muscle stim
-- hot/cold therapy

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complication 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
- Hospitilization
- 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**