



pines wellness center
 CHIROPRACTIC & FUNCTIONAL REHABILITATION

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full Name:		Date:	
Address:			
City		State	Zip
Cell phone:		Home phone:	
Occupation:		Work phone:	
Email address:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Weight:		Height:	
Driver's license number:		Social Security Number:	
Marital status: M S W D		Spouse/guardian name:	
Emergency Contact:		Phone:	
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Who may we thank for referring you? _____			

COMPLAINTS

1.			
2.			
3.			
4.			
5.			
Have you experienced any serious accidents or falls within the Past year? 5 years? Over 5 years? Never?			
If you have experienced an accident, what type was it? Auto Work Home Leisure Sports Other			
1. Are you interested in a weight loss program?	YES	NO	MAYBE
2. Would you take nutritional supplements if indicated?	YES	NO	MAYBE
3. Are you interested in knowing more about how your nutrition affects your overall health and well being?	YES	NO	MAYBE
4. If Dietary changes are indicated would you be willing to make changes to your diet?	YES	NO	MAYBE
5. If specific exercises or stretching would help, would you consider adding them to your program?	YES	NO	MAYBE

Medical History Form

Name: _____ Age: _____ Date of Birth: _____

Medications and dosages:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/Reactions:

_____	_____	_____
_____	_____	_____

Past Medical History

Do you have or have you had any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other: _____

Surgical History

Have you had any of the following surgical procedures? (Please Circle and Include dates)

Back Surgery _____ Neck Surgery _____
Knee Surgery _____ Shoulder Surgery _____
Heart Surgery _____ Other: _____

Family History

Does anyone in your family suffer from any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other: _____

Social History

Social History: Are you: Married Single Divorced Widowed

Do you smoke? YES or NO Packs per day _____

Do you drink alcohol? YES or NO Drinks per week _____

Do you use street drugs? YES or NO

Occupation: Are you working? YES or NO Job Description: _____

Work Restrictions? YES or NO List Restrictions: _____

Do you like your job? YES or NO



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Informed Consent

Patient: _____ **Date:** _____

To the patient: Please read this entire document prior to signing. 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 used by the 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. They may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may sense a feel 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 | *Posture Analysis | *EMS |
| *Radiographic Studies | *Hot/Cold Therapy | *Other _____ |

The material risks inherent in chiropractic adjustments:

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 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 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 risk 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 has been a subject of tremendous disagreement. The indications 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 are 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 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 risk and dangers of remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer 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. I have discussed it with Dr. Robert Kustin 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 my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____

Patient Name: _____

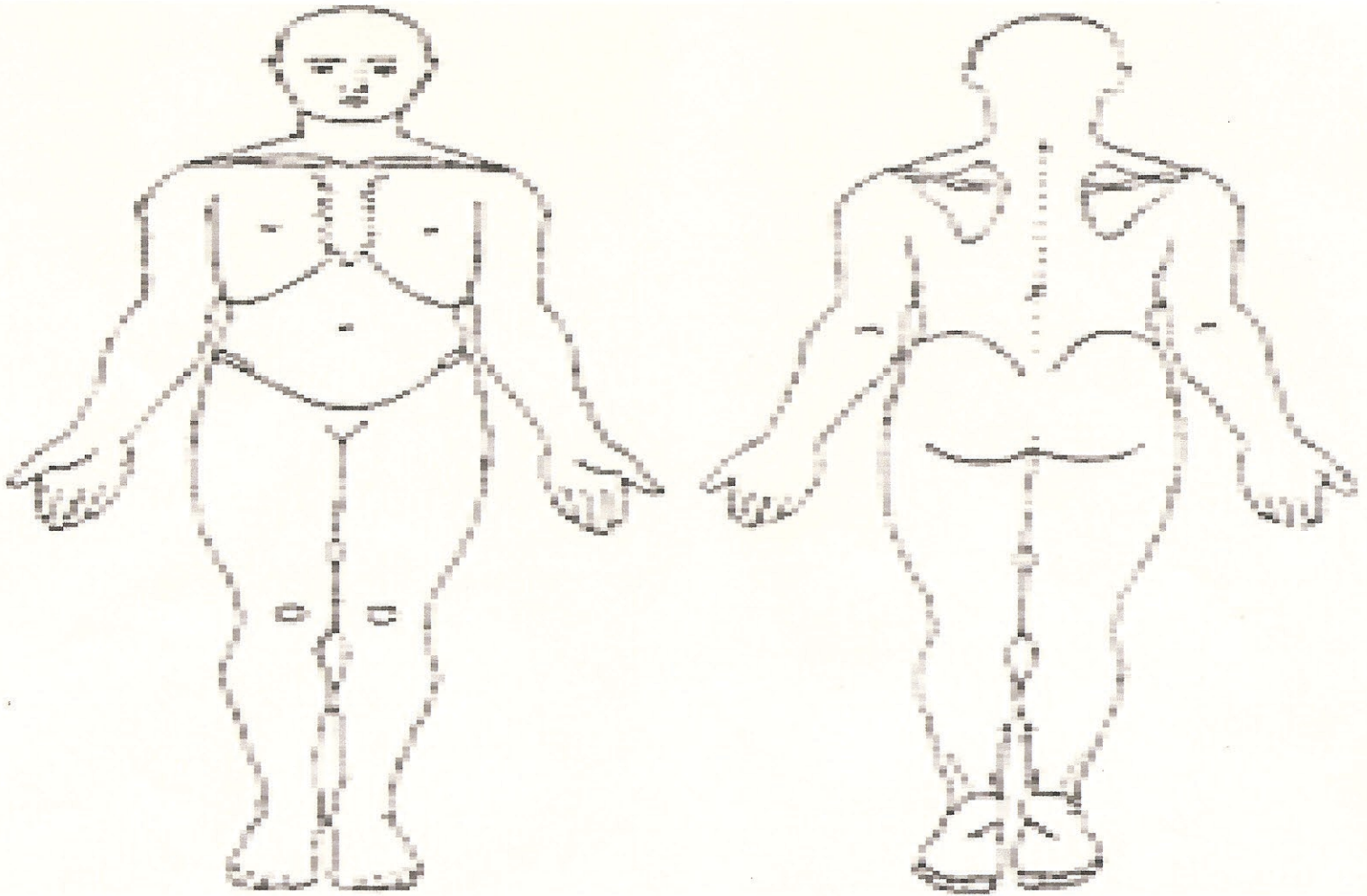
Patient Signature: _____

Doctor’s Signature: _____

SHOW ME WHERE IT HURTS

Mark these drawings according to where your pain is located. Indicate with the symbols the types of pain you experience.

Stabbing = ** Burning = XXX Numbness = \\\ Weakness = +++ Pin & Needles = OOOOO



ABOUT YOUR PAIN

How Long has the pain been present?

The pain is increased when I: Sit Stand Walk Run Bend Lay Exercise

The pain is Improved when I: Sit Stand Walk Run Bend Lay Exercise

Do any of the following help alleviate the pain? Ice Heat Massage Stretching