Anthem Chiropractic
Family Practice • Injuries • Wellness

10170 S. Eastern Ave. #110 Henderson, NV 89052
P: (702) 614.6777
C: (702) 840.9154 | F: (702) 614.6778
www.drderekday.com | info@drderekday.com

PATIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip: _____ Phone (Cell): _____

Email: _____

Employer: _____ Occupation: _____

Work activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Health Ins Co: _____ Was this due to an Auto Collision? ☐ Yes ☐ No

Who is your family doctor? _____

Main Complaint: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No

Rate the severity of your pain on a scale from ☐ Mild ☐ Moderate ☐ Severe (check one)

Type of pain (check one): ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does it interfere with your (check one): ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that is painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down

How often do you have pain? _____

Is your pain constant or does it come and go? _____

OFFICE USE ONLY

Last DOS _____ **HT** _____ **WT** _____ **BP** _____

Prior X-Ray/MRI: _____

Intensity of Pain: ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Constant** ☐ **On & Off**

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HEALTH HISTORY (Prior to accident)

Date of Last: Physical Exam: _____ Spinal X-ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____

Dental X-ray: _____ MRI, CT-Scan, Bone Scan: _____

Please check to indicate if YOU HAVE HAD the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine/Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Coughs
- ☐ Other: _____

_____

_____

Are you pregnant? ☐ Yes ☐ No Due date: _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Habits: ☐ Smoking: Packs/Day: _____ ☐ Alcohol: Drinks/Week: _____

☐ Coffee/Caffeine: Cups/Daily: _____

☐ High Stress Level Reason: _____

PRIOR INJURIES:

Falls: ☐ Yes ☐ No When: _____
Describe: _____

Head Injuries/Concussion: ☐ Yes ☐ No When: _____
Describe: _____

Broken Bones: ☐ Yes ☐ No When: _____
Describe: _____

Dislocations: ☐ Yes ☐ No When: _____
Describe: _____

Auto Injuries/Work Injuries: ☐ Yes ☐ No When: _____
Describe: _____

Prior Neck/Back Surgeries: ☐ Yes ☐ No When: _____
Describe: _____

Other Surgeries: ☐ Yes ☐ No When: _____
Describe: _____

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INFORMED CONSENT

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you under stand 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 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
- ☐ Postural analysis testing
- ☐ Ultrasound
- ☐ Hot/cold therapy
- ☐ EMS
- ☐ Radiographic studies
- ☐ Other: mineral ice, traction, massage, therapeutic exercises, lifestyle and ergonomic instructions, nutritional supplementation and dietary recommendations

Patient should initial each procedure they are consenting to.

The risk 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. Sometimes 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 the 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.

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The ability 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 TREAT (MINOR)

I hereby request and authorize Anthem Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization 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. PLEASE CHECK THE APPROCIATE 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 Anthem Chiropractic 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 being informed of the risks, I hereby give my consent to that treatment.

Dated _____ **Dated** _____

Patient's Name _____ **Doctor's Name** _____

_____ _____

Patient's/Parent or Guardian Signature **Doctor's Signature**

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AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (Printed): _____

Date of Birth: _____ **Social Security Number:** _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Anthem Chiropractic.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to Anthem Chiropractic.

I hereby designate the above named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

_____ _____
Provider Name **Phone**

_____ _____
Provider Name **Phone**

_____ _____
Provider Name **Phone**

Please send records to:

Anthem Chiropractic
10170 S Eastern Ave., Ste. 110
Henderson, NV 89052
Phone: (702) 614-6777
Fax: (702) 614-6778

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**