Adult Health History Form for Progressive Care Chiropractic

Name: _____Today's Date:_____

Age: _____Birth date : mm/dd/yyyy _____ Male Female Intersex Transgender (Circle one)

E mail address: _____

May we email you appt reminders and office related information? **Y N**

Mailing Address:_____City_____Zip_____

Phone:(H)_____ (W)_____ (cell) _____

Marital Status: S M W D (Circle one)

Patient Occupation: _____ Who may we thank for referring you?_____

Emergency Contact Name: _____ Phone: _____

Relationship_____

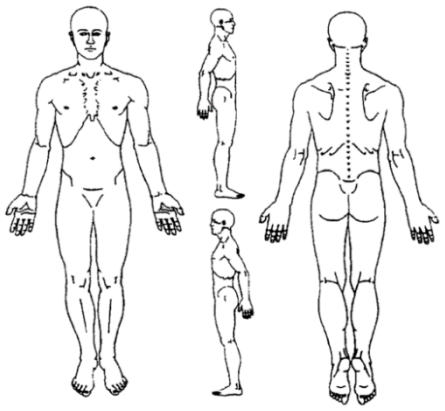
Family doctors Name & Phone: _____

May we contact them: Y N (circle one)

WHY THIS FORM IS IMPORTANT: **Our focus is on assisting people to function optimally, to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.**

#1 Current Health Concern

_____



Rate your pain on a scale of 1 to 10 (1 is minimal, 10 is extreme) _____

Circle or describe its character: **sharp, dull, aching, burning, tingling, throbbing, spasming**

_____

When did it start?_____

What started the symptoms? _____

How often does it occur?_____

What relieves?_____

What aggravates?_____

Does it radiate or cause problems somewhere else? _____

Any change in bowel or bladder function? _____

Any change in vision, dizziness, nausea, or vomiting? _____

Any associated or related concerns? _____

Have you had any other treatments and if so what were the results?

_____

Other health concerns: Please note all other health concerns present or in the past.

_____

For women: Are you pregnant? Yes No Unknown

Disease history: (please circle any that you have experienced)

Allergies, Frequent colds, lowered resistance, Dizziness or lightheadedness, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Heartburn, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Headaches, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Constipation, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease, Fertility problems, Miscarriage, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Pinched nerve, Numbness and tingling, Pins and needles, Parkinson's Disease, Prostate problems, Menstrual pain and cramping, Stroke, Thyroid problem Tonsillitis Ulcers Urinary tract infections, Ulcerative colitis Other: _____

#2 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**

(if yes please explain) _____

Any significant injuries, falls or traumas during adulthood? **Yes No Unsure**

(if yes please explain) _____

Any hospital visits? **Yes No** Have you had any surgeries, fractures, accidents? **Yes No**

Explain and dates _____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**

(if yes, please explain)_____

Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**

(if yes, please explain)_____

What is your usual exercise routine? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? **Yes No** What happened and when? _____

_____

#3 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes No (**If yes, please indicate what you are taking and why) _____

_____

Are you currently taking supplements? **Yes No**(if yes, which ones and why?) _____

_____

Do you smoke? **Yes No Quit** (if yes how much?) _____

Do you drink? **Yes No** (if yes roughly how much?) _____

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**

Do you eat organic? **Yes / No / Occasionally**

Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** _____

#4 Mental/Emotional Stresses
As psychological stress has been shown to negatively affect many systems, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to **10 being extreme**:

Life in general I feel _____ Work and Career I feel _____ Relationships I feel _____
Financial stress I feel _____ Time management I feel ____ Sports & hobbies I feel _____
Health and well-being I feel ____ Quality of sleep I feel ____
If you are experiencing significant or ongoing stress please explain _____
_____
Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain _____

#5 Family Health History
Please note any health issues that are present with **family members** such as parents, siblings, significant other or children. **Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other** _____

#6 Why are you here?
People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check the goals which apply to you so we can accommodate your wishes.

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life ____
Symptom management ____ Healthier immune system ___ Stress reduction ___ Keep me moving___
Optimum function and quality of life ___ Wellness ____ Other_____

CONSENT for examination: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date:_____

Signature:_____ **Witness:**_____

Progressive Care Chiropractic, LLC
770 W. Hampden Ave Suite 105 Englewood, CO 80110

Informed Consent for Treatment at Progressive Care Chiropractic, LLC

It has been determined that my case is suitable for chiropractic care.
After my report of findings, I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.
I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately **1 in 1 million.** To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:
Risk of paralysis or stroke from surgeries or neck pain**: 15, 600 per 1 million**
Risk of death from surgery for neck pain: **6, 900 per 1 million**
Risk of serious gastrointestinal event from a non-steroidal anti-inflammatory drug (e.g. Aspirin, ibuprofen): **1,000 per million**
Risk of stroke following a chiropractic adjustment: **1 per 1 million up to 1 per 5 million**
To put this further into perspective, these studies estimate:
Risk of death before the age of 35 due to smoking cigarettes: **1677 per 1 million**
Annual risk for being injured in a car accident is: **13, 333 per 1 million**
Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is uniquely trained to assess your spine and adjust in ways that significantly diminish your risk.
I have read and understood the remote risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care.
I realize that I may still ask questions to the Doctor at any time after I sign this consent. I understand that my consent can be withdrawn at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date: _____

Signature: _____ **Witness:** _____

Progressive Care Chiropractic, LLC
770 W. Hampden Ave Suite 105 Englewood, CO 80110

Notice of Privacy Practices Acknowledgement
Progressive Care Chiropractic, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____
Attempt_____

Staff Name_____

Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent Form

IMT / TDN involves placing a small needle into the muscle at the trigger point which is typically in a n area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT / TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint paint, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT / TDN provider. If a pneumo is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle puntures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT / TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily Fluids? **Yes NO**
If you marked yes, please discuss with your practitioner.

_____
Please print your name.

_____ _____
Signature Date

☐ **I was offered a copy of this consent and refused.**