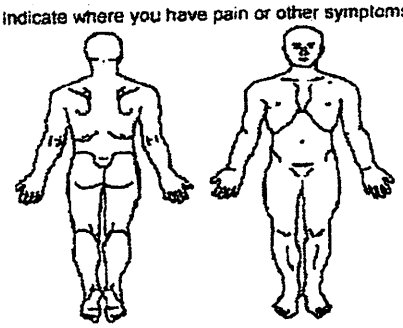
Mars Hill Chiropractic Center

Patient:_____ **D.O.B.**_____ **Date:**_____

1. Briefly Describe your **PRIMARY** complaint:_____

   _____

Indicate where you have pain or other symptoms.



2. Pain is: Sharp Dull Burning Throb Stabbing Numb Ache Other
3. When did your **symptoms** start?_____
4. How did your **symptoms** start? _____
5. Average **pain** intensity:
   In the last 24 hours: no pain **1 2 3 4 5 6 7 8 9 10** worst pain
   In the past week: no pain **1 2 3 4 5 6 7 8 9 10** worst pain
6. How often do you experience your symptoms?
   Constantly (75-100% of the time) Frequently (50-75% of the time) Occasionally (25-50% of the time) Intermittently (0-25%)
7. How are your **symptoms** changing? o Getting better o Not changing o Getting worse
8. What makes your **symptoms** better?_____
9. What makes your **symptoms** worse?_____
10. Have you had this **problem** examined by anyone else?_____
11. What have you done to treat this **problem**?_____

Additional complaints:

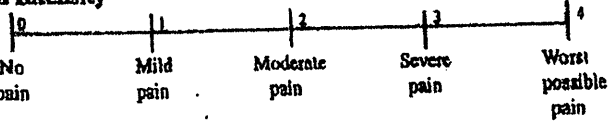
1. _____
2. _____
3. _____

MARS HILL CHIROPRACTIC CENTER

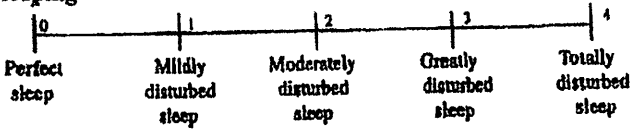
Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

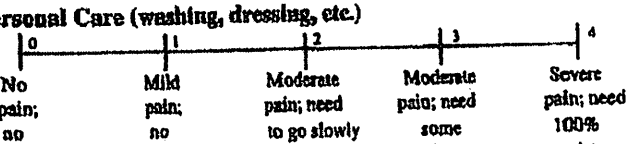
1. Pain Intensity



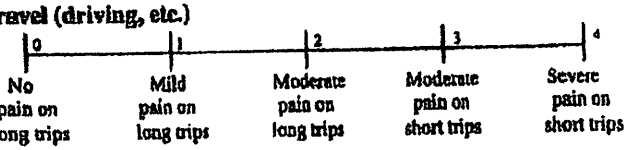
2. Sleeping



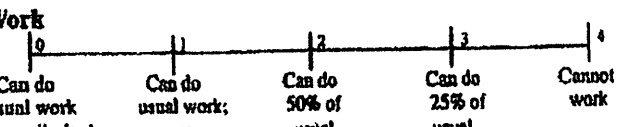
3. Personal Care (washing, dressing, etc.)



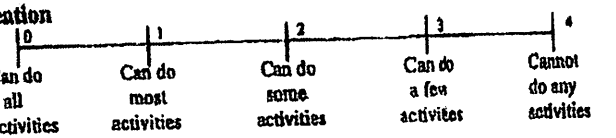
4. Travel (driving, etc.)



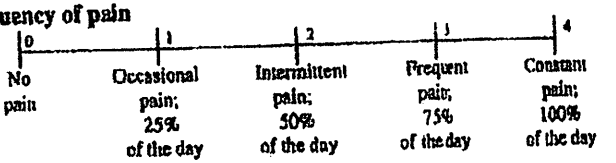
5. Work



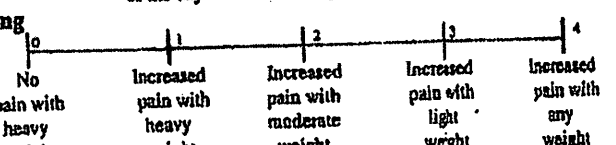
6. Recreation



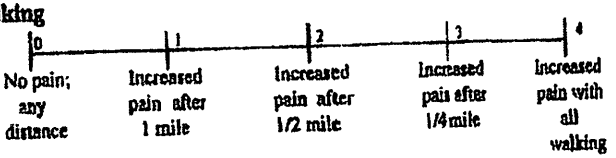
7. Frequency of pain



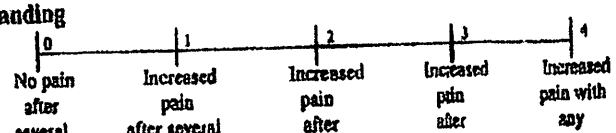
8. Lifting



9. Walking



10. Standing



PATIENT NAME_____ DATE_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which Mars Hill Chiropractic Center may have to use or disclose your health care information. We may have to disclose your health information

- to another health care provider for referral to them for treatment or diagnosis
- to an insurance company or another party if they are responsible for payment of your services for treatment
- amongst the staff within our practice for quality control or administrative purposes.

Your right to limit uses or disclosures

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Mars Hill Chiropractic Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mars Hill Chiropractic Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Signature:_____ Date:_____

Printed Name:_____

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with the chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following a cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, or medical treatments and surgery provided by physicians and surgeons.

By signing this informed consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care received from Mars Hill Chiropractic Center.

Patient Printed Name_____

Patient Signature_____

Legal Guardian Signature_____

Date_____ Witness Signature_____