Essential Project

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"Treating the essential since 2020"

1. PATIENT INFORMATION

NAME: _____ TODAY'S DATE: ___/____/_____

PHONE: __(____)_____ EMAIL ADDRESS:_____

MAILING ADDRESS: _____ CITY:_____ STATE: _____ ZIP:_____

DATE OF BIRTH: ___/____/_____ AGE:_____ GENDER: _____

PROFESSION: _____ EMPLOYER: _____ HRS/WK: _____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____
EMERGENCY CONTACT PHONE: __(____)_____

PRIMARY CARE PHYSICIAN:_____ CITY:_____ STATE:_____
PRIMARY CARE PHONE: __(____)_____

REFERRED BY: _____

2. INSURANCE INFORMATION

HEALTH INSURANCE: ☐ Yes ☐ No COMPANY NAME:_____

IS YOUR CONDITION DUE TO:

-WORK RELATED INJURY? ☐ Yes ☐ No DATE OF INJURY: ___/____/_____

-AUTO ACCIDENT? ☐ Yes ☐ No DATE OF INJURY: ___/____/_____

3. HEALTH QUESTIONNAIRE

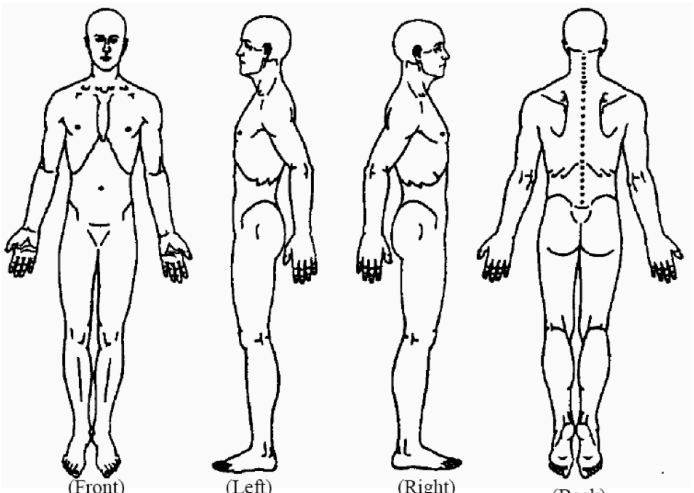
PRIMARY COMPLAINT: _____

ONSET OF ISSUE: ☐ Gradual ☐ Sudden ONSET DATE: ____/____/_____

PROGRESSION OF SYMPTOMS: ☐ Better ☐ Worse ☐ Same

OTHER COMPLAINT (if any): _____

CIRLCE THE AREA(S) OF COMPLAINT BELOW:



☐ ☐ ☐ ☐

PLEASE RATE YOUR PAIN ON THE PAIN SEVERITY SCALE:
1= NO PAIN
10=EXTREME PAIN

CURRENT PAIN
☐☐☐☐☐☐☐☐☐☐

WORST PAIN LEVEL
☐☐☐☐☐☐☐☐☐☐

BEST PAIN LEVEL
☐☐☐☐☐☐☐☐☐☐

TYPE OF PAIN:

☐ Local ☐ Sharp ☐ Tingling ☐ Traveling ☐ Dull ☐ Numb ☐ Achy ☐ Burning

FREQUENCY OF PAIN/SYMPTOMS

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day

Describe what caused the pain: _____

_____

Does any of the following make your symptoms **worse**:

□ lifting □ bending □ pushing □ pulling □ cough □ sneeze □ bowel movement □driving □ sitting □ walking □ running □ standing □ exercise □ work duties

other: _____

Does any of the following make your symptoms **better**:

□ rest □ laying down □ sitting □ walking □ exercise □treatment □ice □heat □treatment other: _____

When are your symptoms at their worst?

□ Morning □ Afternoon □ Evening □In Bed

Have you had this or a similar condition in the past? □ Yes □ No

Explain: _____

What treatment have you received for this condition:

□ Medication □ Surgery □ Physical Therapy □ Chiropractic □ None □ Other _____

Results: _____

Have you detected any possible relationship of your current complaint with any of the following?

□ Muscle Weakness □ Bowel/Bladder problems □ Digestion □ Cardiac/Respiratory

□ Other: _____

4. PAST HEALTH & SOCIAL HISTORY

1. Have you ever had any **major illnesses**, **injuries**, **hospitalizations**, or **surgeries**? If Yes, please list below:

DATE	INJURY / ILLNESS / SURGERIES	TREATMENT	RESULTS

2. Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):_____

_____

3. Please list any allergies (including medications):

_____

_____

4. What is your height? _____ What is your weight?_____

5. Do you regularly exercise? □ Yes □ No

If yes, how many hours a week and what activities: _____

6. During the past month have you been bothered by feeling down, depressed or hopeless? □ Yes □ No

7. During the past month have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

8. Is this something for which you would like help? □ Yes □ Yes, but not today □ No

9. Do you drink alcohol? □ Yes □ No How many glasses per week? _____

10. Do use tobacco/nicotine products? □ Yes □ No How many mgs per day? _____

11. Do you need support quitting substances? □ Yes □ No

12. Circle **ANY** conditions you had in the **past**/have **currently**:

AIDS/HIV	Bladder Issues	Epilepsy	Irregular Cycle	Shingles
Allergies	Cancer	Headaches	Kidney Issues	Sinus Infections
Anxiety/ Depression	Fatigue	Heart Disease	Leg Pain	Stroke
Arm Pain	Diabetes (I or II)	Herniated Disc	Osteoporosis	Thyroid Issues
Arthritis	Digestion Issues	High Blood Pressure	Prostate Issues	TMJ
Asthma	Ear ringing	Insomnia	Rheumatoid Arthritis	Other_____

Please read and Sign the below form before examination and treatment.

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4. PAST HEALTH & SOCIAL HISTORY

Medical doctors, chiropractic doctors and physical therapists that perform procedures are required by law to obtain your informed consent before beginning treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Exercise prescription may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. Some risks and complications associated with therapy are as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments. Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Trigger Point Dry Needling (TDN): is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to 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. The symptoms of 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. Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. 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 TND is unlikely. As required by the Colorado

Department of Regulatory Agencies, Susan Hansen, DC is qualified to perform trigger point dry needling.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ Signature of Patient Date: _____

_____ Signature of Witness Date: _____