**PATIENT HISTORY**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Called Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female (circle one) Marital Status: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children:\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Workplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best way to get a hold of you: Text/Call/E-mail

Major Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had the condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had this condition before? Yes/No When? \_\_\_\_\_\_\_\_

Have you lost work days? Yes/No How many? \_\_\_\_\_\_ Was the injury related to: Work/Auto Accident/Other\_\_\_\_\_\_\_\_\_\_

When did you last see a Chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. visited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you helped? Yes/No

Why did you see this Chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why are you changing Chiropractors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What spinal maintenance programs were you given to follow to maximize the future stability of your spine and did you follow this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications (prescription or over the counter) for this complaint? Yes/No If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the complaints you are currently dealing with Today:**

* Head
	+ Feels Heavy
	+ Dizziness
	+ Fainting
	+ Light Headed
	+ Memory Loss
	+ Loss of Balance
	+ Eye
		- Pain Behind Eyes
		- Sensitive to Light
		- Eye Strain
		- Loss of Focus
		- Double Vision
	+ Ear
		- Pain (Right/Left/Both)
		- Hearing Loss (Rt/Lft/Both)
		- Equilibrium Problems
	+ Loss of Smell
	+ Sinus Trouble
	+ Loss of Taste
	+ Mental Dullness
	+ TMJ Pain
	+ Headaches
		- Entire Head, Back of Head, Forehead, Temples
		- Migraine
		- Tension
		- Sinus
	+ Shoulder Pain (Right/Left/ Between/Both)
* Arm Pain
	+ - Hand (Right/Left/Both)
		- Upper Arm (Right/Left/ Both)
	+ Loss of Grip (Rt/Lft/Both)
	+ Cold Hands
	+ Restricted Motion
* Chest
	+ Chest Pain
	+ Rib Pain (Right/Left/Both)
	+ Shortness of Breath
	+ Palpitation
* Abdomen
	+ Nausea/Vomiting
	+ Nervous Stomach
	+ Constipation
	+ Diarrhea
	+ Gas
	+ Hiatal Hernia
* Mid Back
	+ Pain
	+ Stiffness
	+ Muscle Spasms
	+ Stabbing Pain
	+ Pain between Shoulder Blades
* Lower Back
	+ Pain
	+ Stiffness
	+ Muscle Spasms
	+ Restricted Motion
* Buttocks
	+ Pain (Right/Left/Both)
	+ Numbness (Right/Left/Both)
* Hips
	+ Pain (Right/Left/Both)
	+ Numbness (Right/Left/Both)
* Leg
	+ Pain (Right/Left/Both)
	+ Cramps (Right/Left/Both)
* Knee Pain (Right/Left/Both)
* Ankle Pain (Right/Left/Both)
* Foot
	+ Pain (Right/Left/Both/Toes)
	+ Numbness (Right/Left/Both/Toes)
* Difficulty
	+ Sitting
	+ Standing
	+ Stooping
	+ Bending
	+ Rising from Seated
	+ Rising from Lying
	+ Difficulty Walking
	+ Difficulty Riding
	+ Difficulty Working
	+ Difficulty Lifting (Light/ Moderate/Heavy) Things
	+ Difficulty Repeated Lifting
* Reproductive Issues
	+ Pain with Menses
	+ Cramping with Menses
	+ Irregular Menses
	+ PMS syndrome
	+ Decreased Sex Drive
	+ Impotency
* Groin Pain
* Neck
	+ Pain
	+ Stiffness
	+ Restricted Motion
	+ Muscle Spasms (Right/Left/Both Sides)
* Misc
	+ Allergy
		- Sinus Trouble
	+ Nervousness
	+ Stress
	+ Unexplained Weight Loss

 **Briefly Describe the accident, injury, or illness:** ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle any of the previous treatments or tests for this condition:**

Accupressure Accupuncture Antibiotics Cervical Collar Chemotherapy Physical Therapy CT scan

Diathermy Gait Training Hot Packs Cold Packs Hydromassage Infrared Therapy Massages

None Orthotics Traction Ultrasound UV therapy Muscle Stimulation X-rays

Other Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any current work restrictions due to this condition?** ◊ Off work From:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ ◊ Light Duty From: \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_

**Were you admitted to the hospital due to this condition?** ◊ Yes ◊ No Date admitted:\_\_\_\_\_\_\_\_\_\_ Released:\_\_\_\_\_\_\_\_\_\_

**Circle any of the following conditions or illnesses you have had in the past:**

Abdominal Pain Abnormal Menstruation Abnormal Weight Gain/Loss Adrenal Issues Allergies Alzheimer’s Anemia Ankle Pain Appendicitis Arrhythmia Arthritis Asthma Back Pain Bladder Infection Bleeding Bronchitis Cancer (Kind)\_\_\_\_\_\_\_\_\_ Cardiovascular Disease Cerebral Palsy Chest Pains COPD Chronic Pain Chronic Sinusitis Constipation Cirrhosis of the Liver Cystic Fibrosis Depression Diabetes Diverticulitis Dizziness Ear Infections Elbow Pain Endometriosis Epilepsy Excessive Thirst Fainting Fatigue Flu Frequent Colds Gall Bladder Disorder Gas/Bloating Head Injury Headaches Heart Attack Hemophilia Hemorrhoids Hepatitis Hernia Herniated Disc High Blood Pressure Hip Pain HIV/AIDS Hormone Replacement Hypertension Immunization Impotence Inflammatory Bowel Disease Insomnia Intestinal Problems Jaw Pain Joint Stiffness/Swelling Kidney Stones Knee Pain Large Bowel Obstruction Liver disorder Lower Back Pain Leg Pain Meningitis Menopause Mid Back Pain Migraines Multiple Sclerosis Myasthenia Gravis Neck Pain Parkinson’s Pneumonia Pregnancy Prostate Problems Psoriasis Ringing in Ears Shoulder Pain Sickle-Cell Disease Sinus Problems Sleep Apnea Stroke Ulcer Upper Arm Pain Upper Back Pain Upper Leg Pain Urinary Tract Infection Wrist Pain Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle any of the following Conditions your parents, grandparents or siblings have had:**

ADD/ADHD AIDS Allergy Alzheimer’s Aneurysm Anorexia Arthritis Asthma Cancer Cardiac Arrhythmias Cardiovascular Disease Cataracts Chronic Sinusitis Cleft Palate Colic Constipation Coronary Heart Disease Cystic Fibrosis Depression Diabetes Type 1 / 2 Digestive Problems Epilepsy Gall Stones Gestational Diabetes Headaches Heart Disease High Blood Pressure Hyper/Hypo-Thyroidism Lung Disease Migraines Multiple Sclerosis Obesity Osteoporosis Postural Imbalance Rheumatoid Arthritis Scoliosis Seizures Sinus Problems Stroke TMJ Disorder Tonsillitis Ulcers Weight Problems Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you:** Drink Alcohol: Y / N Cups/day?\_\_\_\_\_\_\_\_\_\_ Take Recreational Drugs: Y / N Smoke: Y / N Packs/day?\_\_\_\_\_\_\_\_\_ Drink coffee: Y / N Cups/day?\_\_\_\_\_\_\_\_\_\_ Drink Soft Drinks? Y / N Cans/day?\_\_\_\_\_\_\_\_\_\_ Water? Cups/day?\_\_\_\_\_\_\_\_\_

What Medications do you take?

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Vitamin Supplements do you take?

1.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any Allergies: Y / N If yes what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Is your health Philosophy? (What should you do to be healthy? ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you want us to handle your problem(s)?

\_\_\_- Temporary Relief: Help the symptom but not fix the problem.

\_\_\_- Maximum Correction: Correct the cause of the problem/symptom for maximum stability in the future.

Why did you come into our clinic and what are your expectations of us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favorite activities/hobbies to do now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your current problems affecting these activities/hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities are you looking forward to doing in retirement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who would you like to be doing these activities with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of 1-10 (1 being the least 10 being the most)**

How committed are you to being at your maximum health Potential? 1 2 3 4 5 6 7 8 9 10

How important is it for your family to be at their maximum health potential? 1 2 3 4 5 6 7 8 9 10

How committed are you to preventing arthritis and maximizing your spinal stability? 1 2 3 4 5 6 7 8 9 10

Auburn Chiropractic Clinic’s Financial Policy

It is our office policy that all services rendered are charged directly to you, the patient, and that you are ultimately responsible or all payments regardless of whether or not this office accepts insurance assignment.

**AS A PATIENT, YOU ARE EXPECTED TO…**

* Pay 100% of your first visit on the day of the first visit
* Sign a payment plan at your report of findings on your second visit
* Honor your payment plan
* Give a twenty four (24) hour notice if you are unable to keep a scheduled appointment (there is a $25 charge if a notice is not given)

We accept cash, checks, money orders, Master Card, and Visa.

If you do not follow these expectations, you will be subject to any of all of the following: discontinuation of care, interest charges, court costs, and/or small claims or collection agency involvement.

**Patients without insurance:** All payments are expected at the time of service or at the end of each week. Patient balances may not exceed $250 at any time, or professional services may be terminated.

**Patients with insurance:** Deductibles and co-payments are expected at the time of service or at the end of each week. Your co-insurance balance may not exceed $250, or professional service may be terminated. If your insurance company has not paind within 30 days, you must contact the insurance company regarding payment. You are responsible for the bill in full. Remember the contract is between you and your insurance provider.

I have read the above. I understand what is expected of me and I agree to honor the payment plan we set up at my report of findings on my second visit. I understand that if I do not follow the above expectations, I will be subject to any of the above stated actions including discontinuation of care and/or collection agency involvement. I also understand that if I have insurance, the contract is between me and the insurance company, and that I am ultimately responsible for all my charges.

Auburn Chiropractic Clinic’s HIPAA Patient Notice of Privacy Practices

Auburn Chiropractic Clinic strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time you may request to view or receive a copy of our HIPAA Policy.

 To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA Policy has been made available to you upon your request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Patient Signature Staff Signature Date

Informed Consent (Doctor-Patient Relationship in Chiropractic)

**Chiropractic**: It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor’s procedures often depends on its environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health services.

**Analysis**: A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

**Diagnosis**: Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VCS, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are ultimately responsible for the final decision.

**Informed Consent for Chiropractic Care**: A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis performed. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care.

**Results**: The purpose of chiropractic services is to promote natural health through a reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less then expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

**To the Patient**: Please discuss any questions or problems with the doctor **BEFORE** signing the informed consent portion.

I have read, and understand the foregoing.

**Please use the diagram and letters below to indicate the type and location of your pain and sensations:**

A-Aching

B-Burning

S-Stabbing

N-Numbness

P-Pins and Needles

O-Other

**Please indicate the level of pain you are experiencing today on the following scale (0-No pain to 10-Severe Pain):**

1 2 3 4 5 6 7 8 9 10