Whom may we thank for referring you to this office? _____
Quem te referiu?

APPLICATION FOR CARE AT REACH CHIROPRACTIC

Today's Date/Data: _____ HRN: _____

PATIENT DEMOGRAPHICS/INFORMACOES DO PACIENTE

Name: _____ DOB: _____-_____-_____ Age: _____ □ Male □ Female
Nome Data de Nascimento Idade Masculino Feminino

Address: _____ City: _____ State: _____ Zip: _____
Endereco Cidade Estado CEP

E-mail: _____ Home Phone: _____ Work Phone: _____
E-mail Telefone/Casa Telefone/Trabalho

Mobile Phone:_____ Cell Phone Provider:_____
Celular Operadora de Celular

Marital Status: □ Single □ Married Do you have Insurance: □ Yes □ No
Estado Civil Solteiro Casado Voce tem seguro de saude: Sim Nao

Social Security #: _____ Driver's License #: _____
Numero do Social Security Numero da Driver's License

Employer: _____ Occupation: _____
Nome do Empregador Ocupacao

Spouse's Name:_____ Spouse's Employer:_____
Nome do Conjuge Nome do Empregador do Conjuge

Number of children and ages: _____
Numero de filhos(as) e idade

Name & Number of Emergency Contact:_____ Relationship: _____
Nome e Telefone em caso de emergencia Relacao

HISTORY of COMPLAINT/HISTORICO

Please identify the condition(s) that brought you to this office: Primary: _____
Identifique a condicao que te traz a clinica Primario

Secondary: _____ Third: _____ Fourth: _____
Secundario Terceiro Quarta

When did the problem(s) begin? _____ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM
Quando comecou o problema? Quando o problema esta pior? AM PM meio do dia fim do dia

How long does it last? □ Constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week
Quanto tempo dura? Constante **OU** Vai e volta durante o dia **OU** Vai e volta durante a semana

How did the injury happen? _____
Como aconteceu?

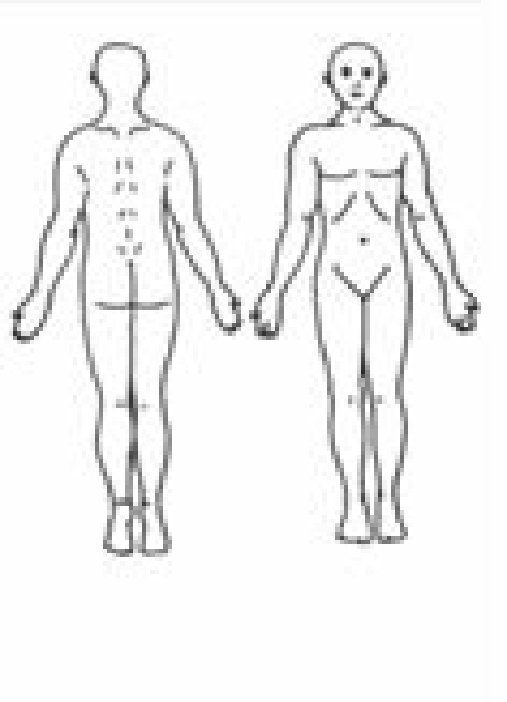
Condition(s) ever been treated by anyone in the past? □No □ Yes **if yes,** when: _____ by whom? _____
Ja recebeu tratamento para essa condicao no passado? Nao Sim Se sim, quando: Por quem?

How long were you under care? _____ What were the results? _____
Por quanto tempo recebeu tratamento: Qual foram os resultados

Name of Previous Chiropractor: _____ ☐ **N/A**
Nome do ultimo quiropraxista **N/A**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
Marque as areas no diagram com as letras para descrever seus sintomas:

R = Radiating	**B = B**urning	**D = D**ull	**A =** Aching	**N = N**umbness	**S = S**harp/**S**tabbing	**T = T**ingling
R = Irradiando	B = Queimando	D = Profundo	A = Dolorido	N = Dormente	S = Aguda/Pontada	T = Formigando



What relieves your symptoms?
O que alivia seus sintomas
_____

What makes your symptoms feel worse?
O que agrava seus sintomas
_____

Is your problem the result of **ANY** type of accident? □ Yes □ No
O seu problem foi resultado de **QUALQUER** tipo de acidente? Sim Nao

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:
Identifique qualquer outra lesao na coluna, grande ou pequena, que a doutora deve saber:
_____
_____

PATIENT'S NAME: _____ HR#: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PAST HISTORY/HISTORICO PESSOAL:

Have you suffered with any of this or a similar problem in the past? □ No □ Yes **If yes,** how many times? _____
Voce ja sofreu com esse problema ou similar no passado? Nao Sim Se sim, quantas vezes?

When was the last episode? _____ How did the injury happen? _____
Quando foi o ultimo episodio? Como aconteceu?

Other forms of treatment tried: □ No □ Yes **If yes,** please state **what** type of treatment: _____
Outras formas de tratamento: Nao Sim Se sim, qual tipo de tratamento:

Who provided it: _____ **How long ago? _____**What were the results. □ Favorable □ Unfavorable
Quem forneceu: Quanto tempo? Qual foi o resultado: Favoravel Desfavoravel

→ please explain. _____
→ explique

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:
Porfavor identifique qualquer tipo de trabalho no passado que pode ter algum efeito fisico no seu corpo:
_____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:
POR FAVOR identifique TODAS condicoes **PASSADAS e ATUAIS** que voce creer ter contribuido au problema presente:

	HOW LONG AGO **QUANTO TEMPO ATRAS**	**TYPE OF CARE RECEIVED** **TIPO DE TRATAMENTO FEITO**	**BY WHOM** **FEITO POR**
INJURIES/LESOES →			
SURGERIES/CIRURGIAS →			
CHILDHOOD DISEASES/ **DOENCAS DE INFANCIA** →			
ADULT DISEASES/ **DOENCAS DE ADULTO** →			

SOCIAL HISTORY/HISTORICO SOCIAL:

1. Smoking: □cigars □ pipe □ cigarettes How often? □ Daily □ Weekends □ Occasionally □ Never
Fumar: charuto cachimbo cigarros Frequencia? Diario Finais de semana Ocasionalmente Nunca

2. Alcoholic Beverage: consumption occurs □ Daily □ Weekends □ Occasionally □ Never
Bebidas Alcoholicas: consumo ocorre Diario Finais de semana Ocasionalmente Nunca

3. Recreational Drug use: □ Daily □ Weekends □ Occasionally □ Never
Drogas recreacionais: Diario Finais de semana Ocasionalmente Nunca

FAMILY HISTORY/HISTORICO FAMILIAR:

1. Does anyone in your family suffer with the same condition(s)? □ No □ Yes
Algum em sua familia sofre com a mesma condicao? Nao Sim
If yes whom: □ grandmother □ grandfather □ mother □ father □ sister(s) □ brother(s) □ son(s) □ daughter(s)
Se sim, quem: Avó Avô mãe pai irmã irmão filhos filhas
Have they ever been treated for their condition? □ No □ Yes □ I don't know
Alguem recebeu tratamento para a condicao? Nao Sim Eu nao sei

2. Any other hereditary conditions the doctor should be aware of? □ No □ Yes: _____
Qualquer outra condicao hereditaria que a doutora deve saber? Nao Sim

PATIENT'S NAME: _____ HR#: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL)/ATIVIDATES DIARIAS

Please identify how your current condition affects the following:

Por favor identifique como sua condicao afeta os seguintes:

ACTIVITIES/ATIVIDATES:	**EFFECT:**			
Carry children/groceries Carregar criancas/compras	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Lift children/groceries Levantar criancas/compras	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Sit to Stand Sentado a Levantado	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Climb Stairs Subir Escadas	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Sitting/Driving +30 mins Sentado/Dirigindo +30 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Computer Use +30 mins Uso de computador +30 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Read/Concentrate Ler/Concentrar	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Getting Dressed Se vestir	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Personal Care Cuidados pessoais	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Sexual Activities Atividades sexuais	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Sleep Dormir	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Static Sitting +15 mins Ficar Sentado +15 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Static Standing +15 mins Ficar de pe +15 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Yard/House Work Trabalho de jardim/casa	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Walking +15 mins Caminhar +15 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Running+15 mins Correr +15 mins	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER
Other: _____ Outras:	NO EFFECT NAO TEM EFEITO	PAINFUL(CAN DO) DOLORIDO (POSSO FAZER)	PAINFUL (LIMITS) DOLORIDO (LIMITADO)	UNABLE TO PERFORM NAO POSSO FAZER

PATIENT'S NAME: _____ HR#: _____ Date: _____

List Prescription & Non-Prescription drugs you take: _____

Liste todas prescricoes e remedios que esta tomando _____

_____

_____

Please mark **P** for in the **Past**, **C** for **Currently Have**, or **N** for **Never**:

Por favor marque **P** para **Passado**, **A** para **Atual**, ou **N** para **Nunca**

___Headache Dor de cabeca	___Pregnant (Now) Gravida (Agora)	___Dizziness Tontura	___Prostate Problems Problemas de prostata	___Ulcers Ulceras
___Neck Pain Dor no pescoco	___Frequent Colds/Flu Gripes e resfriados frequentes	___Loss of Balance Perca de equilibrio	___Impotence/Sexual Dysfxn. Impotencia/Disfuncoes sexuais	___Heartburn Azia
___Jaw Pain, TMJ Dor na mandibula	___Convulsions/Epilepsy Convulsoes/Epilepsia	___Fainting Desmaio	___Digestive Problems Problemas digestivos	___Heart Problems Problemas de coracao
___Shoulder Pain Dor no ombro	___Tremors Tremores	___Double Vision Visao dupla	___Colon Problems Problemas no colon	___High Blood Pressure Pressao alta
___Upper Back Pain Dor na parte superior das costas	___Chest Pain Dor no torax	___Blurred Vision Visao embasada	___Diarrhea/Constipation Diareia/Constipacao	___Low Blood Pressure Pressao baixa
___Mid Back Pain Dor na parte do meio das costas	___Pain w/Cough/Sneeze Dor quando Tosse/Espirra	___Ringing in Ears Ruido no ouvido	___Menopausal Problems Menopausa	___Asthma Asma
___Low Back Pain Dor na lombar	___Foot or Knee Problems Problemas com pes ou joelho	___Hearing Loss Perca de audicao	___Menstrual Problems Problemas Menstruais	___Difficulty Breathing Problemas de respiraco
___Hip Pain Dor no quadril	___Sinus/Drainage Problems Sinusite/Drenagem	___Depression Depressao	___PMS TPM	___Lung Problems Problemas de pulmao
___Back Curvature Ma postura	___Swollen/Painful Joints Juntas inchadas e doloridas	___Irritable Irritabilidade	___Bed Wetting Urinar na cama	___Kidney Problems Problemas de rins
___Scoliosis Escoliose	___Skin Problems Problemas de pele	___Mood Changes Mudancas de humor	___Learning Disability Dificuldade de aprendizagem	___Gallbladder Problems Vesicula
___Numb/Tingling arms, hands, fingers Dormencia/Formigamento nas maos, bracos e dedos		___ADD/ADHD	___Eating Disorder Desordem```5; alimentar	___Liver Problems Problemas no figado
___Numb/Tingling legs, feet, toes Dormencia/Formigamento nos pes, pernas e dedos		___Allergies Alergias	___Trouble Sleeping Problemas para dormir	___Hepatitis (A,B,C) Hepatitis
___Broken Bone/Fracture Fratura	___Dislocations Dislocacao	___Tumors Tumores	___Rheumatoid Arthritis Artrite Reumatica	___Disability Incapacidade
___Heart Attack Ataque Cardiaco	___Osteoarthritis Osteoartrite	___ Cancer Cancer	___Diabetes Diabete	___Cerebral Vascular Vascular Cerebral

___ Other serious conditions:
Outra condicao critica

PATIENT'S NAME: _____ HR#: _____ Date: _____

JDD, DC 5/2011

REACH CHIROPRACTIC - NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, **or as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or a general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Lorena Jesus at (678) 981-5399. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. It you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

Reach Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of the Reach Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and presents.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in this reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#

_____	_____
Patient's Signature	Date

_____	_____
Witness	Date

I hereby authorize payment to be made directly to Reach Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Reach Chiropractic for any and all services I receive at this office.

Eu autorizo que o pagamento seja feito diretamente a Reach Chiropractic para todos os benefícios que podem ser pagáveis segundo meu plano de saúde ou de quaisquer outras fontes colaterais . Autorizo a utilização desta aplicação ou das suas cópias para a finalidade do tratamento dos pedidos e efetuar pagamentos, e reconheco ainda que esta atribuição de benefícios de nenhuma maneira alivia -me da responsabilidade de pagamento e que continuo a ser financeiramente responsável a Reach Chiropractic por todos os serviços que recebo neste escritório.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**
Assinatura do paciente ou responsavel **Data de Conclusao**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**
Assinatura do(a) doutor(a) **Data de Revisao**

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. **THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.** DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF REACH CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. **BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____ - _____ - _____ _____

Patient or Authorized Person's Signature **Date Completed** **Age**
Assinatura do paciente ou responsavel **Data de Conclusao** **Idade**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT REACH CHIROPRACTIC.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**
Assinatura do paciente ou responsavel **Data de Conclusao**

INSURANCE POLICIES AND FEE SCHEDULE

Consultation- includes practice member history. This service is complimentary.
Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check.
Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrument assisted. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.
X-rays- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care.

PATIENT'S NAME: _____ HR#: _____ Date: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Reach Chiropractic/Lorena Jesus, DC/John Sparagna, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**
Assinatura do paciente ou responsavel **Data de Conclusao**

_____ _____ - _____ - _____

Doctor/Witness Signature **Date Form Reviewed**
Assinatura do(a) doutor(a) **Data de Revisao**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**
Assinatura do paciente ou responsavel **Data de Conclusao**

_____

IF PATIENT IS A MINOR, PLEASE STATE RELATIONSHIP
SE O PACIENTE E DE MENOR, QUAL O RELACIONAMENTO AO MENOR

_____ _____ - _____ - _____

Doctor/Witness Signature **Date Form Reviewed**
Assinatura do(a) doutor(a) **Data de Revisao**

PATIENT'S NAME: _____ HR#: _____ Date: _____