SHERIDAN CHIROPRACTIC NEW PATIENT INTAKE CT _____ Date: ___/___/___

PATIENT INFORMATION

First Name:_____ Last Name: _____Middle Name Initial: _____

DOB (Month/Day/Year):___/___/_____Age:_____Gender: Male / Female Social Sec. #: _____

Address: _____ City:_____Zip Code: _____

Cell #:_____ Home #: _____ Email Address: _____

Emergency Contact & #: _____ Relationship: ☐ Spouse ☐ Parent ☐ Other:_____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor # of Children: ____

Primary Doctor: _____ City: _____ Phone #: _____

Health Insurance Carrier: _____ Member ID #: _____ Group #: _____

Employment Status: *(Check one)*

☐ Employed ☐ Self-Employed ☐ PT Student ☐ FT Student ☐ Retired ☐ Disability ☐ Other:_____
☐ Highest Education Attained: _____

Time Loss: *(Check one)*
☐ N/A
☐ NO time loss from work due to injury, currently working with no limitations
☐ NO time loss from work due to injury, BUT do have limitations
☐ Patient reports time loss due to injury. Indicate number of day(s) or week(s); Date last worked _____

Employer Name: _____ Occupation: _____ # Hours Worked: _____

Address: _____ City:_____Zip Code: _____

Work #: _____ Physical Stress Level at work? ☐ Low ☐ Medium ☐ High

Attorney Name: _____ Case Manager: _____ Phone #:_____

ACCIDENT HISTORY

Date of Injury: ___/___/___
☐ Motor Vehicle Collision How many cars? _____ ☐ Work Related Incident ☐ Non-work Related
☐ Sports Related Incident ☐ Slip & Fall ☐ Other: _____

Immediately following the incident: *(Check one)* ☐ N/A
☐ Ambulance / Paramedics called
☐ Treated at the scene
☐ Transported to hospital by ambulance
☐ Went to hospital on own
☐ Diagnostics Performed
☐ Medication Prescribed
☐ Follow-up recommended
☐ Other: _____

Date: ___/___/___ Hospital name: _____City: _____ Phone #: _____

SHERIDAN CHIROPRACTIC NEW PATIENT INTAKE CT _____ Date: ___/___/___

List the types of diagnostic testing that have been performed at any other facilities you received care from for this injury: ☐ N/A

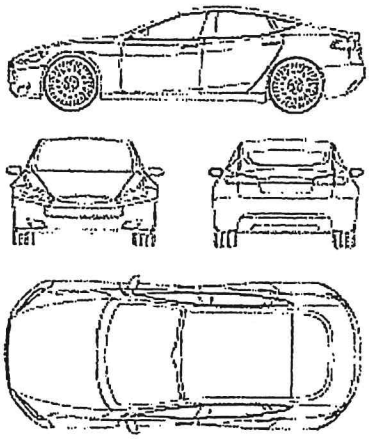
☐ X-rays ☐ MRI ☐ CT scan ☐ Bone Scan ☐ Myelogram ☐ EMG ☐ Discogram ☐ Other: _____

Where? _____ City: _____ Phone #: _____ ☐ Same as above

Specifics of the collision:

☐ Driver ☐ Passenger
☐ Front Seat ☐ Back Seat
☐ Braced ☐ Not Braced
☐ Shocked ☐ Car Towed
☐ Head DID NOT strike object
☐ Head did strike object
☐ Airbags Deployed
☐ Flash of light seen on impact
☐ Police Report Made

Circle damage to *your* car:



☐ Rear-end
☐ T-Bone/Side Impact
☐ Head on

Describe your accident in 1-2 sentences:

_____

_____

_____

Mechanism of Injury:

Were you surprised by the impact? ☐ Yes ☐ No

In relation to the back of your head was your headrest set: ☐ Low ☐ Middle ☐ High

Where was your head facing at the time of impact? ☐ Left ☐ Forward ☐ Right ☐ Unknown

Were you leaning forward at the time of impact? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Were you rendered unconscious as a result of the incident? ☐ Yes ☐ No *(If yes, how long?_____)*

Did you feel pain immediately after the incident? ☐ Yes ☐ No *(If no, when?_____)*

Car Specifications:

Year and type of vehicle **you** were in? Year: _____ Make: _____ Model: _____
☐ Small ☐ Mid-size ☐ Large ☐ Unknown

Your approximate speed? _____ MPH

Year and type of **other** vehicle? Year: _____ Make: _____ Model: _____
☐ Small ☐ Mid-size ☐ Large ☐ Unknown

Approximate speed of the **other** vehicle? _____ MPH

PERSONAL HEALTH HISTORY

Mark if you have had any of the following symptoms in the past 3 years: ☐ N/A

Before/After Injury		Before/After Injury		Before/After Injury		Before/After Injury	
☐ / ☐	Unexplained fevers	☐ / ☐	Easy Bruising	☐ / ☐	Stomach Pain	☐ / ☐	Blood in Urine
☐ / ☐	Night Sweats	☐ / ☐	Excessive Bleeding	☐ / ☐	Changes in Bowel	☐ / ☐	Morning Stiffness
☐ / ☐	Weight Loss 10lbs+	☐ / ☐	Lump in Neck, Armpit or Groin	☐ / ☐	Persistent Diarrhea	☐ / ☐	Eye Redness
☐ / ☐	Loss of Appetite	☐ / ☐	Chest Pain or Tightness	☐ / ☐	Excessive Constipation	☐ / ☐	Muscle Tenderness
☐ / ☐	Excessive Fatigue	☐ / ☐	Persistent/Unusual Cough	☐ / ☐	Dark Black Stools	☐ / ☐	Dry Eyes or Mouth
☐ / ☐	Problems w/ Depression	☐ / ☐	Trouble Breathing w/ Exercise	☐ / ☐	Bloody Stools	☐ / ☐	Skin Rashes
☐ / ☐	Difficulty Sleeping	☐ / ☐	Trouble Breathing Lying Flat	☐ / ☐	Pain/Burning when Urinating	☐ / ☐	Joint Pain/Swelling
☐ / ☐	Unusual Stress at Home	☐ / ☐	Cough Up Blood	☐ / ☐	Difficulty Urinating	☐ / ☐	Anxiety
☐ / ☐	Unusual Stress at Work	☐ / ☐	Swollen Ankles	☐ / ☐	Need to Urinate Frequently	☐ / ☐	Irritability

Injuries you may have had in the past: ☐ N/A

☐ Auto Accidents Date: ___/___/___
☐ Work Injury Date: ___/___/___
☐ Broken Bones Date: ___/___/___
☐ Back Injury Date: ___/___/___
☐ Fall (severe) Date: ___/___/___
☐ Head Injury Date: ___/___/___

Illnesses you have ever been diagnosed with as having or suffered from: ☐ N/A

☐ Muscle Disorder	☐ Asthma	☐ Osteoarthritis	☐ Coughing Blood
☐ Nervous System Disorder	☐ Broken Bones	☐ Epilepsy	☐ Circulatory Problems
☐ Bone Disorder	☐ Intestinal Problems	☐ Alcoholism	☐ Kidney/Bladder Problems
☐ Rheumatoid Arthritis	☐ Seizures/Convulsions	☐ Drug Addiction	☐ Heart Disease
☐ Allergies	☐ Congenital Disease	☐ Strokes	☐ Tumors
☐ HIV	☐ Excessive Bleeding	☐ Cancer	☐ Depression
☐ Gallbladder Issues	☐ High Blood Pressure	☐ Ulcer	☐ Ear/Throat Infection
☐ Diabetes	☐ Low Blood Pressure	☐ Hernias	☐ Pacemaker

I have seen the following physician/professional for <u>this</u> condition: ☐ N/A

☐ Chiropractor _____ Date of last visit: ___/___/___
☐ Massage Therapist _____ Date of last visit: ___/___/___
☐ Orthopedist _____ Date of last visit: ___/___/___
☐ Physical Therapist _____ Date of last visit: ___/___/___
☐ Physician _____ Date of last visit: ___/___/___
☐ Psychiatrist/Psych. _____ Date of last visit: ___/___/___
☐ Acupuncture _____ Date of last visit: ___/___/___

☐ N/A

<u>Please list any surgeries you have had and list dates:</u>

_____ _____

_____ _____

Select all the treatments you have had for **this** condition: ☐ N/A

☐ Ice ☐ Heat/Ultrasound ☐ Electrical Stimulation ☐ Exercises ☐ Bed Rest ☐ Massage
☐ Chiropractic ☐ Osteopathy ☐ Injections ☐ Acupuncture ☐ Naturopathy
☐ Traction/Decompression ☐ Other: _____

MEDICATION CURRENTLY BEING TAKEN

☐None

_____ _____ _____
_____ _____ _____

Select all that apply:
☐ Smoker ☐ Non-smoker ☐ Drinks Alcohol Socially ☐ Does not drink alcohol

Female Patients:
Most recent menstrual cycle: Date: ___/___/___ ☐ Pregnant? _____ weeks

FAMILY HISTORY ☐ N/A

☐ Muscle Disorder	☐ Asthma	☐ Osteoarthritis	☐ Coughing Blood
☐ Nervous System Disorder	☐ Broken Bones	☐ Epilepsy	☐ Circulatory Problems
☐ Bone Disorder	☐ Intestinal Problems	☐ Alcoholism	☐ Kidney/Bladder Problems
☐ Rheumatoid Arthritis	☐ Seizures/Convulsions	☐ Drug Addiction	☐ Heart Disease
☐ Allergies	☐ Congenital Disease	☐ Strokes	☐ Tumors
☐ HIV	☐ Excessive Bleeding	☐ Cancer	☐ Depression
☐ Gallbladder Issues	☐ High Blood Pressure	☐ Ulcer	☐ Ear/Throat Infection
☐ Diabetes	☐ Low Blood Pressure	☐ Hernias	☐ Pacemaker

CURRENT INJURIES

When did your symptoms appear? Date: ___/___/___ Is this condition getting worse? ☐ Yes ☐ No

Activities or movements that are difficult / painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Circle your pain on the below scale of 0 to 10:

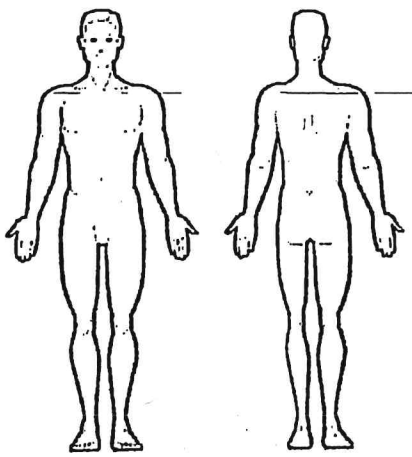
(At rest) ☺ No pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain
(With Activity) ☺ No pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

How often are you in pain?
☐ Constant ☐ Intermittent
☐ Frequent ☐ Occasional

Description of pain: *(Circle all that apply.)*

(DL)	Dull	(SO)	Sore
(A)	Achy	(T)	Tight
(S)	Sharp	(P)	Pins & Needles
(SB)	Stabbing	(ST)	Shooting
(AY)	Annoying	(SF)	Stiff
(B)	Burning	(TH)	Throbbing
(W)	Weak	(SP)	Superficial
(N)	Numb	(H)	Hot
(TG)	Tingling	(C)	Cold
(D)	Deep	Other:	_____

Circle on the areas of your pain:



FOR DOCTOR'S USE BELOW. SKIP TO PAGE 7.

HEENT
- ☐ The patient is normocephalic, non-traumatic
- ☐ Pupils are equal, round and reactive to light & accommodation
- ☐ TM's are clear

GASTROINTESTINAL
- ☐ Abdomen is soft, non-tender
- ☐ Bowel sounds are normoactive
- ☐ No history or present complaints regarding gastrointestinal system

CARDIOVASCULAR/PULMONARY
- ☐ No complaints or history of heart murmur, blood pressure Problems, or other vascular disorders
- ☐ Heart exam reveals a regular rate with no murmurs, gallops or rubs
- ☐ Lungs are clear to percussion and auscultation

Blood Pressure _____ Pulse Rate _____

GRIP STRENGTH
Test 1 Right _____ Left _____ ☐ With Pain on R L
Test 2 Right _____ Left _____ ☐ Without Pain
Test 3 Right _____ Left _____

NEUROLOGICAL EXAMINATION
- ☐ Cranial nerves II-IX are grossly intact
- ☐ Romberg's Test
- ☐ Cerebellum function is grossly within normal limits
- ☐ Patient is alert and oriented to time, place, and person
- ☐ Reflexes are equal and reactive bilaterally in both upper and lower extremities and are +2
- ☐ Wartenberg's pinwheel testing showed HYPERESTHESIA / HYPOESTHESIA at dermatomal distributions _____ on the RIGHT / LEFT
- ☐ Sensation intact to all primary modalities
- ☐ Patient can heel and toe walk without difficulty
- ☐ Toes are down going pathological reflex is absent for Babinski Sign
- ☐ Motor testing of the upper extremities normal
- ☐ Motor testing of the lower extremities normal

UROGENITAL
☐ There is no complaint of frequency, urgency, or difficulty with urination.

ORTHOPEDIC EXAMS

☐Adson's Maneuver:	☐Left ☐Right ☐Bilateral ☐NA	☐Max Cervical Comp:	☐Left ☐Right ☐Bilateral ☐NA
☐Apley's Compression	☐Left ☐Right ☐Bilateral ☐NA	☐McMurray's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Apley's Distraction	☐Left ☐Right ☐Bilateral ☐NA	☐Mill's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Braggard's Sign:	☐Left ☐Right ☐Bilateral ☐NA	☐O'Donohue Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Cervical Distraction:	☐Left ☐Right ☐Bilateral ☐NA	☐Patrick's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Cozen's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Phalen's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Deep Inhalation Chest Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Schepelmann's Sign Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Drawer's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Shoulder Depression Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Dugas' Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Straight Leg Raiser Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Ely's Heel Buttock Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Supraspinatus Press Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Finklestein's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Soto-Hall Test:	☐Positive ☐Negative
☐George's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Tinel's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Hoover's Sign	☐Left ☐Right ☐Bilateral ☐NA	☐Thessaly's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Kemp's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Valgus Stress Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Lasegue's SLR Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Valsalva Maneuver:	☐Positive ☐Negative
☐Magnuson's Test:	☐Left ☐Right ☐Bilateral ☐NA	☐Yergason's Test:	☐Left ☐Right ☐Bilateral ☐NA
☐Mankopf's Sign:	☐Left ☐Right ☐Bilateral ☐NA	☐Other: _____	☐Left ☐Right ☐Bilateral ☐NA

☐The performance of the malingering exams were negative and/or were not performed due to the positive integrity of the patient and/or due to the absence of examiner perceived needed.

SHERIDAN CHIROPRACTIC NEW PATIENT INTAKE CT _____ Date: ___/___/___

CERVICAL	Restrictive	Degree	Normal	Pain
Flexion	☐		50	
Extension	☐		60	
Left Lat Flex	☐		45	
Rt Lat Flex	☐		45	
Left Rot	☐		80	
Rt Rot	☐		80	

LUMBAR	Restrictive	Degree	Normal	Pain
Flexion	☐		50	
Extension	☐		25	
Left Lat Flex	☐		25	
Rt Lat Flex	☐		25	
Left Rot	☐		30	
Rt Rot	☐		30	

SPINAL EXAMS

☐ Spinal examination consisted of static and motion palpation of the cervical, thoracic, lumbar, and pelvis (all or separate).
It included:

- ☐ Intervertebral joint play analysis
- ☐ Comparative leg length analysis
- ☐ Range of Motion Evaluation

ARTICULAR DYSFUNCTION

These articular dysfunctions are associated & accompanied by:

- ☐ Joint Edema
- ☐ Joint Capsulitis
- ☐ Deep & Superficial Myospasms

☐ There is muscle splinting and tenderness upon digital palpation at the levels of articular dysfunction.
☐ There is pain on percussion of the spinous processes at these levels as well.

The examination revealed dysfunctions/vertebral subluxations at the following levels:

C 1 2 3 4 5 6 7 T 1 2 3 4 5 6 7 8 9 10 11 12 L 1 2 3 4 5 Sacrum Ilium R L

There are myofascial trigger points located in the following musculature:

Radiology:

UPPER EXTREMITY: **LOWER EXTREMITY:** **OTHER:**

CAUSATION:

☐ In my opinion, the above diagnoses are a direct result of the date of the incident noted above.

Are your findings and diagnosis consistent with patient's account of injury or onset of illness?
☐ Yes ☐No If "no," please explain:

Is there any other current condition that will impede or delay the patient's recovery?
☐ Yes ☐No If "yes," please explain:

PLAN RECOMMENDATIONS:

- ☐ 4 times/week
- ☐ 3 times/week
- ☐ 2 times/week
- ☐ Once a week
- ☐ Every 2 weeks
- ☐ Once a month

_____ Visits

Patient will be re-evaluated in:
- ☐ One month
- ☐ 1 week
- ☐ 2 weeks
- ☐ 3 weeks

☐ Chiropractic adjustments (CMT), Activator (ACT), Neuromuscular Re-Education (NR), Joint Mobilization (JM), Myofascial Release (MR), Intersegmental Traction (IT), Electrical Stimulation (EMS), Mechanical Massage (MM), Ultrasound (US), Diathermy (D), Hot/Cold Pack (HP/CP), Interferential (ITF), Transcutaneous Nerve Stimulation (TENS), Infrared (IF), Therapeutic Exercises/Outside Office (TE)/(TEO), Physician's Education Group (PEG)

☐ The patient's condition has stabilized. I have recommended periodic chiropractic check-ups in order to maintain the patient's progress.

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Sheridan Chiropractic, Inc
Shamus Sheridan, D.C. ~ Sean Sheridan, D.C.
26900 Newport Rd Ste 110 Menifee, CA 92584 Phone: (951)672-8060

NOTICE OF DOCTOR'S LIEN

Patient:_____ Date of Loss:_____

I do hereby authorize **Sheridan Chiropractic, Inc.** to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct to you, my attorney, to pay directly to said doctor such sums and may be due to and owing him for the medical service(s) rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sims from any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident and instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance the entire balance due and payable.

I acknowledge that a holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Dated:_____ **Patient Signature:**_____

Printed Name:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor named above. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney fees and cost.

Dated:_____ **Attorney Signature:**_____

Firm Name:_____

HOW WE PROTECT YOUR PRIVATE HEALTH INFORMATION

My "protected health information" (PHI), means personal health information, including my demographic information, collected from me and/or created or received by my physician, medical assistant or other healthcare provider. PHI may relate to my past, present or future physical or mental health or condition that identifies me, or there is a reasonable basis that the information may identify me.

I consent to the use or disclosure of my PHI by Sheridan Chiropractic, Inc. or any owner, employee, contractor or other representative thereof (collectively, "Sheridan Chiropractic"), for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or conduct healthcare operations of Sheridan Chiropractic. I understand that Sheridan Chiropractic may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my PHI for the above-stated purposes. My signature on this document establishes my consent to the use or disclosure of my PHI for the above-stated purposes.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations by Sheridan Chiropractic. Sheridan Chiropractic is not required to agree to the restrictions that I may request. However, if Sheridan Chiropractic agrees to a restriction that I request, the restriction is binding upon Sheridan Chiropractic.

I understand I have a right to review the office's Notice of Privacy Practices prior to signing this document. Sheridan Chiropractic's Notice of Privacy has been provided to me. Sheridan Chiropractic's Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations by Sheridan Chiropractic's office. Notice of Privacy Practices also describe my rights and Sheridan Chiropractic's duties with respect to my PHI.

I acknowledge and understand that Sheridan Chiropractic has the right to change the privacy practices described in Sheridan Chiropractic's Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting Sheridan Chiropractic's Privacy Officer at dd.sheridanchiro@gmail.com, to request a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Sheridan Chiropractic has taken action in reliance on this agreement.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding Sheridan Chiropractic's Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient's Name (PRINT): _____ Date: _____

Patient's Signature: _____

Witness Name (PRINT): _____ Date: _____

Witness Signature: _____

INFORMED CONSENT DOCUMENT

TO THE PATIENT: Please read this entire document prior to signing it. It is important that you understand the information contained. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. Sheridan Chiropractic will use that procedure to treat you. Doctors may use hands, or mechanical instrument(s) upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis I Examination/Treatment: As part of the analysis, exam and treatment, I consent to the following:
PLEASE INITIAL EACH PROCEDURE YOU CONSENT TO.

_____ Spinal Manipulative Therapy	_____ Palpation	_____ Vital Signs
_____ Basic Neurological Testing	_____ Muscle Strength Testing	_____ Range of Motion Testing
_____ Postural Analysis Testing	_____ EMS	_____ Orthopedic Testing

The risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, disclocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring: Fractures are rare occurrences and generally a result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-rays. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose to use one of the above noted treatments options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Sheridan Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE SIGN AND DATE BELOW WHERE APPROPRIATE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Sheridan Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to any treatment rendered to me by Sheridan Chiropractic, it's doctors and staff.

PATIENT NAME (PRINTED)	SIGNATURE	DATE
PATIENT NAME (PRINTED)	SIGNATURE OF PARENT/GUARDIAN (IF MINOR)	DATE
DOCTOR NAME (PRINTED)	DOCTOR'S SIGNATURE	DATE

Revised 9/21

AUTHORIZATION TO RELEASE RECORDS

Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C. | John Chapman, D.C.

REQUESTING FACILITY:

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F. (951) 672-7490

☐ 1485 Spruce St. Ste. I
Riverside, CA 92507
P. (951) 462-1285
F. (951) 462-1308

Patient: _____ P: _____

DOB: ____/____/____ DOI: ____/____/____

REQUEST SENT TO: _____

_____

_____

REQUESTED INFORMATION:

☐ X-Ray Image(s) ☐ MRI Report(s) ☐ Other: _____

_____

Patient Signature: _____ Date: ____/____/____

NOTE: IF PATIENT IS UNDER 18 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.