MOVEMENT CLINIC

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Established Patient Information – Complaint Update – Review of Systems

Patient's Full Name: _____ **Date:** _____

Please notify us if your insurance or contact information has changed.

Presenting Complaint

Primary complaint: _____

When did your complaint begin? _____ **Have you had this complaint before? ☐ Yes ☐ No**

If yes, when? _____ **Did you receive treatment? ☐ Yes ☐ No**

If yes, by whom? Outcome? _____

Was the onset: ☐ Gradual ☐ Sudden Since its onset, has it become: ☐ Worse ☐ Better ☐ Stayed the same

Describe what caused the pain: _____

Have you tried any self-treatments, taken any medication (over-the-counter or prescription), or been treated by another Chiropractor or healthcare provider? ☐ Yes ☐ No

If yes, explain: _____

Results: _____

Have you had any X-RAY, MRI, or CT studies? ☐ Yes ☐ No

If yes, date and location: _____

Pain Diagram

Please mark areas of pain using these symbols.

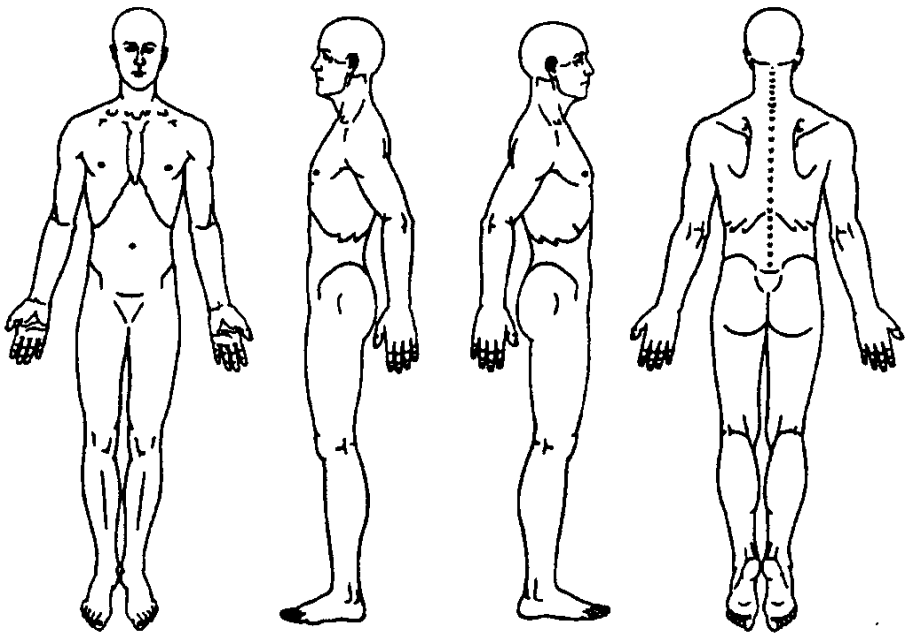
+++ Burning

Dull or Ache

*** Numbness or Tingling

=== Throbbing

000 Stabbing or Sharp



Presenting Complaint Continued

List region of pain and circle number which represents intensity of pain at its BEST and WORST on the same line.

Region: _____ **No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable**

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Please indicate the area of complaint you are referring to, if needed. You can mark more than one box, and indicate more than one region of complaint.

Describe the quality of the complaint:

☐ Burning
☐ Cramping
☐ Dull ache
☐ Giving away
☐ Locking/catching
☐ Numbness/loss of sensation
☐ Popping/grinding
☐ Sharp
☐ Stabbing
☐ Throbbing
☐ Tightness/tension
☐ Tingling
☐ Other: _____

Describe location of complaint:

☐ Very specific area
☐ General, localized area
☐ Spreads to different area
☐ Shoots to different area
☐ Other: _____

How often are you aware of the complaint?

☐ Intermittent (0-25% of time)
☐ Occasional (25-50% of time)
☐ Frequent (50-75% of time)
☐ Constant (75-100% of time)

Is your complaint more specific to a time of day?

☐ Upon waking
☐ In the morning
☐ In the afternoon
☐ At night
☐ No specific time of day

Does your complaint wake you up at night?

☐ Yes
☐ No

Does complaint interfere with your daily activities?

☐ Annoyance, no interference
☐ Tolerated, some interference
☐ Significant interference
☐ Prevents most activity

Please indicate activities that complaint interferes with:

☐ Driving
☐ Exercise
☐ Hobbies
☐ Household chores
☐ School
☐ Sleep
☐ Sports
☐ Work
☐ Other: _____

How long does complaint typically last?

☐ Less than 1 minute
☐ Less than 5 minutes
☐ Less than 30 minutes
☐ Less than 1 hour
☐ More than 1 hour
☐ Most of the day
☐ All day
☐ Varies from day to day
☐ Other: _____

Do any of the following make complaint better, even temporarily?

☐ Certain position: _____
☐ Chiropractic care
☐ Exercise
☐ Heat
☐ Ice
☐ Injections
☐ Lying down
☐ Medication
☐ Physical therapy
☐ Rest/no movement
☐ Sitting
☐ Standing
☐ Walking
☐ Other: _____
☐ Can't make complaint better

Do any of the following make complaint worse?

☐ Bowel movement
☐ Cough/sneeze
☐ Bending
☐ Caring for family
☐ Changing positions
☐ Driving/riding
☐ Getting in/out of car
☐ Household chores
☐ Lifting
☐ Lying down
☐ Pulling
☐ Pushing
☐ Reaching
☐ Running
☐ Shopping
☐ Sitting
☐ Sports
☐ Squatting
☐ Stairs
☐ Standing
☐ Twisting/turning
☐ Walking
☐ Working
☐ Other: _____
☐ Can't make complaint worse

Review of Systems

As you review the following list, please check any problems or conditions that you are CURRENTLY experiencing or have experienced in the PAST 12 MONTHS. If you do not have any of the problems listed, please check NONE.

General Health

☐ Chills
☐ Fatigue
☐ Fever
☐ Loss of appetite
☐ Night sweats
☐ Recent weight gain (6 months)
☐ Recent weight loss (6 months)
☐ **NONE**

Endocrine

☐ Diabetes (Type I or Type II)
☐ Excessive thirst or hunger
☐ Frequent urination
☐ Heat or cold sensitivity
☐ Sweating
☐ Thyroid condition: _____
☐ **NONE**

Psychiatric

☐ Anxiety
☐ Depression
☐ Eating disorder
☐ Nervousness
☐ Other: _____
☐ **NONE**

Ears, Nose, Mouth, Throat

☐ Difficulty swallowing
☐ Earaches
☐ Loss of hearing
☐ Loss of smell
☐ Loss of taste
☐ Painful chewing
☐ Ringing in ears
☐ Sinus infection or discharge
☐ Sores in mouth
☐ Other: _____
☐ **NONE**

Gastrointestinal

☐ Abnormal stools
☐ Blood in stools
☐ Heart burn or indigestion
☐ Increasing constipation
☐ Nausea
☐ Painful bowel movements
☐ Persistent diarrhea
☐ Stomach or abdominal pain
☐ Ulcer
☐ Vomiting
☐ Other: _____
☐ **NONE**

Respiratory

☐ Asthma
☐ Blood in cough
☐ Chronic or frequent cough
☐ Pneumonia
☐ Other: _____
☐ **NONE**

Cardiovascular

☐ Discoloration of hands or feet
☐ High blood pressure
☐ High cholesterol
☐ Irregular heart beat or palpitations
☐ Leg pain or cramps with walking
☐ Pain in chest
☐ Shortness of breath with activity
☐ Swelling in hands or feet
☐ Other: _____
☐ **NONE**

Hematologic/Lymphatic

☐ Bleeding disorder: _____
☐ Bruise easily
☐ Swollen or enlarged lymph nodes
☐ **NONE**

Eyes

☐ Blind spots
☐ Blurred vision
☐ Double vision
☐ Glasses or Contacts
☐ Injury
☐ Loss of vision
☐ Pain
☐ Other: _____
☐ **NONE**

Genitourinary

☐ Blood in urine or discoloration
☐ Female: irregular bleeding
☐ Female: irregular periods
☐ Female: menstrual pain
☐ Incontinence
☐ Kidney stones
☐ Male: prostate disease
☐ Male: testicle pain or mass
☐ Painful or burning urination
☐ Sexual difficulty
☐ Sexually transmitted disease
☐ Urgency with urination
☐ Urine retention
☐ Other: _____
☐ **NONE**

Musculoskeletal

☐ Arthritis
☐ Difficulty walking
☐ Grind or clench teeth
☐ Joint pain
☐ Joint stiffness
☐ Joint swelling
☐ Limp
☐ Muscle cramps
☐ Muscle pain or tenderness
☐ Other: _____
☐ **NONE**

Neurological

☐ Balance trouble
☐ Black outs/loss of consciousness
☐ Change in handwriting
☐ Clumsiness
☐ Difficulty speaking
☐ Difficulty walking
☐ Dizziness
☐ Facial drooping
☐ Fainting
☐ Head Injury
☐ Headaches
☐ Light-headed
☐ Memory loss
☐ Mental confusion
☐ Migraines
☐ Mini-Stroke
☐ Neuropathy
☐ Numbness (loss of sensation)
☐ Paralysis
☐ Stroke
☐ Tingling
☐ Tremors
☐ Vertigo (room spinning)
☐ Weakness
☐ Other: _____
☐ **NONE**

Skin

☐ Breast lump or discharge
☐ Color changes
☐ Hair loss
☐ Itching
☐ Nail changes
☐ Rash
☐ Sores or lesions
☐ Other: _____
☐ **NONE**

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic Examination and Treatment On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending, twisting, and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor of Chiropractic or staff may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues of the body. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to or refuse certain aspects of care once therapeutic options have been presented.

Permission for Physical Contact I understand that, in the course of various chiropractic examination procedures and treatment methods, the Doctor of Chiropractic or other staff may have to examine and physically contact portions of my body.

Do you wish to have another staff member present during examination and treatment?

☐ **Yes** ☐ **No**

Risks of Chiropractic Care and Treatment I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves, and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8 – 5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand, and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of Chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if for some reason I am unable to reach or contact the practice, that I should telephone my primary healthcare provider or present myself to the nearest hospital emergency room.

Alternative Treatments Available I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider, and possibly surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time.

Consent By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to, and authorize Jess T. Brower, DC and the staff at the Movement Clinic to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the Doctor of Chiropractic's scope of practice. I attest that the information provided regarding my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

_____

Signature (Doctor of Chiropractic)

_____

Date