Healing Arts Chiropractic

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Home Phone (____) ____-_____ Mobile Phone (____) ____-_____

E-mail address: _____

Referred by**:** _____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED:_____ DATE _____

Health History Form

All information is strictly confidential.

Client Name: _____ **Today's Date:**_____

I. Major Complaint(s), in order of significance:

	Severe	Moderate	Slight	
1.	❑	❑	❑	_____
2.	❑	❑	❑	_____
3.	❑	❑	❑	_____

How do the above conditions impair your daily activities? _____

_____

II. Patient Medical History:

Please list any medications you are taking, or have taken, and for how long (attach separate sheet if necessary)

Medications	Reason for Taking	Date Started/Stopped	Dosage

Prescribing Physician name: _____ List medications you are allergic to: _____

Briefly list all major past illnesses, hospitalizations, surgeries, operations, fractures, car accidents or major trauma you have experienced. Include date, outcome, etc.

Illnesses: _____

Trauma: _____

Check off any of the below surgeries you have had:

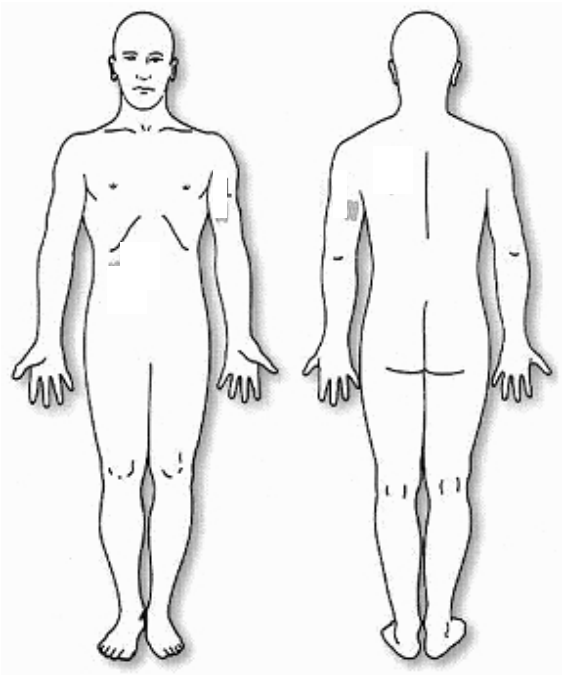
❑ Appendectomy	❑ Biopsies	❑ Dental Surgery	❑ Gallstones	❑ Implants/Prostheses
❑ Arthroscopy	❑ Cholecystectomy	❑ Eye Surgery	❑ Hysterectomy	❑ Kidney Stones
❑ Breast Implants	❑ C-Section	❑ Fracture	❑ Hernia	❑ Laparoscopy ❑ Other

Surgeries or Operations: _____

Other major illnesses you have had:_____

III. Pain & Scars

Please clearly mark any problem areas with an “x” and any scars with an “s”



If you have pain, is it:

❑ Sharp ❑ Burning ❑ Aching ❑ Cramping
❑ Dull ❑ Moving ❑ Fixed ❑ Constant
❑ Intermittent ❑ Other:_____

Do the following lessen the pain?

❑ Pressure ❑ Cold ❑ Ice ❑ Heat
❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

Do the following worsen the pain?

❑ Pressure ❑ Cold ❑ Ice ❑ Heat
❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

Specific movements or activities that aggravate the pain_____

Does this condition affect your sleep in any way? ❑ Yes ❑ No

How bad is your pain currently on a scale from 1-10 (1 = no pain, 10 = unbearable pain):

1 2 3 4 5 6 7 8 9 10

III. Family Medical History

Please list (and specify if necessary) any condition that you or a member of your family has experienced.

	Self	Mother/Father	Brother/Sister	Child	Grandparent Maternal/Paternal	Aunt/Uncle
Alcohol/Drug Abuse						
Allergies/Sinus						
Anemia/Blood Disorder						
Arthritis						
Birth Defect						
Cancer/Type						
Diabetes						
Depression/Anxiety						
Mental Health Disorder						
High Cholesterol						
Heart Disease						
High Blood Pressure						
Obesity						
Thyroid Disorder						
Stroke						
Other						

Were you breast-fed as a child: ❑ Yes ❑ No ❑ Unsure

IV. Dietary Assessment

Please check the boxes in regards to how often you eat or drink the listed types of foods.

	More than Once Daily	Daily	3 Times per week	Once per week	Twice a month	Less or Never
Grains, Breads, Cereals	❑	❑	❑	❑	❑	❑
Milk & Dairy Products	❑	❑	❑	❑	❑	❑
Eggs	❑	❑	❑	❑	❑	❑
Meat, Poultry, Fish	❑	❑	❑	❑	❑	❑
Beans, Peas & Legumes	❑	❑	❑	❑	❑	❑
Fruits	❑	❑	❑	❑	❑	❑
Vegetables	❑	❑	❑	❑	❑	❑
Soy Products	❑	❑	❑	❑	❑	❑
Nuts & Seeds	❑	❑	❑	❑	❑	❑
Popcorn & Chips	❑	❑	❑	❑	❑	❑
Spicy Food	❑	❑	❑	❑	❑	❑
Chocolate	❑	❑	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑	❑	❑
Soda, Sugar or Candy	❑	❑	❑	❑	❑	❑
Fast Food	❑	❑	❑	❑	❑	❑

Are you on a special diet? ❑ Yes ❑ No If yes, please describe: _____

Do you have any known food allergies, sensitivities or intolerances (ie lactose, gluten)? ❑ Yes ❑ No

If yes, please describe: _____

Please list any supplements you are taking, or have taken, and for how long:

Vitamin/Mineral/Supplement	Reason for Taking	Date Started	Dosage

V. Lifestyle (Sleep, Exercise, Stress)

Rate your sleep quality. Check all that apply

❑ Wake up tired ❑ Nightmares ❑ Restless Legs ❑ Bruxing ❑ Other: _____

❑ Sleep Apnea ❑ Snoring ❑ Difficulty falling asleep ❑ Wake up during the night (usually at: ____)

What time do you usually go to sleep? _____ How many hours do you sleep per night on average? _____

Do you exercise? ❑Yes ❑No If yes, what type of exercise?

❑ Walking ❑ Spinning ❑ Marathon (full / half / frequency per year: _____)
❑ Running ❑ Dance ❑ Martial Arts (please specify: _____)
❑ Weightlifting ❑ Aerobics ❑ Team Sports
❑ Triathlon ❑ Cross Fit ❑ Kettle Bell Training
❑ Biking ❑ General Cardio ❑ Other: _____

How often do you exercise: ❑ 1-2 times per week ❑ 3-4 times per week ❑ 5+ times per week

How long is your average exercise session? ❑ 30 min ❑ 60 min ❑ 90 min ❑ over 90 min

VI. Additional Health Information

Women only:

Regular menstrual cycle?: ❑ Yes ❑ No
Avg. number of days (period to period): _____

Flow is: ❑ Heavy ❑ Light ❑ None
Days of flow: 1 2 3 4 5 6 7+

Menstrual Cramps:
❑ Mild ❑ Moderate ❑ Severe

Frequency of cramps:
❑ Monthly ❑ Other (describe how often):_____

❑ Pre-menstrual syndrome (PMS). If yes, check symptoms that apply:

❑ Food cravings ❑ Irritability ❑ Water retention ❑ Breast swelling/tenderness
❑ Crying easily ❑ Headaches ❑ Migraines ❑ Other: _____

❑ Birth Control Pill Use Date started: _____ Date stopped: _____
❑ Bleeding between periods
❑ Abnormal PAP smear What class? _____ Date of last PAP smear: _____
❑ Vaginal discharge
❑ Menopausal Symptoms Which?_____
❑ Spotting ❑ During period ❑ Between periods
❑ Painful Intercourse ❑ Past ❑ Present
❑ Breast Lumps/Fibrocystic ❑ Past ❑ Present
❑ Vaginal Infections/Yeast ❑ Past ❑ Present How many times per year:_____
❑ Sexual Dysfunction ❑ Past ❑ Present
Describe: _____
❑ Infertility ❑ Past ❑ Present
Treatments: _____

Men only:

❑ Benign prostatic hypertrophy (BPH) ❑ nausea Completed TURP; Date(s)_____
❑ Testicular pain
❑ Erectile Dysfunction
❑ Premature ejaculation
❑ Feeling of coldness or numbness in external genitalia
❑ Urinary Difficulty/pain
❑ Other_____

Other comments:

_____

_____

_____

_____

Please sign and date:

Print name:

Signature: **Date:**

Birth Process, Childhood Growth and Development

Please fill out to the best of your ability and knowledge

Regarding *YOUR* birth process:	Circle One	Explain
Was the delivery long/difficult?	Yes No	
Forceps or extraction used?	Yes No	
Cesarean/C-Section?	Yes No	
Breach/Cephalic?	Yes No	
Type of Facility?	Home Hospital	
Mother given drugs during delivery?	Yes No	
Was labor induced?	Yes No	

Growth and Development:

Were you breast fed?	Yes No	
Health Education?	Yes No	
Childhood illnesses?	Yes No	
Ear infections/Colic/Asthma?	Yes No	
Attention Deficit?	Yes No	
Antibiotics?	Yes No	
Drugs; Rx/OTC/Recreational?	Yes No	
Surgery?	Yes No	
Hospitalizations?	Yes No	
Sports or other physical activities?	Yes No	
Injuries during sports?	Yes No	
Auto Accidents?	Yes No	
Did you have other traumas?	Yes No	
Did you ever break any bones?	Yes No	

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian ☐ Gluten-free ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
	1	2	3	
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Muscle weakness
174	O	O	O	Lack of Stamina
175	O	O	O	Drowsiness after eating
176	O	O	O	Muscular soreness
177	O	O	O	Rapid heart beat
178	O	O	O	Hyper-irritable
179	O	O	O	Feeling of a band around your head
180	O	O	O	Melancholia (feeling of sadness)
181	O	O	O	Swelling of ankles
182	O	O	O	Diminished urination
183	O	O	O	Tendency to consume sweets or carbohydrates
184	O	O	O	Muscle spasms
185	O	O	O	Blurred vision
186	O	O	O	Loss of muscular control
187	O	O	O	Numbness
188	O	O	O	Night sweats
189	O	O	O	Rapid digestion
190	O	O	O	Sensitivity to noise
191	O	O	O	Redness of palms of hands and bottom of feet
192	O	O	O	Visible veins on chest and abdomen
193	O	O	O	Hemorrhoids
194	O	O	O	Apprehension (feeling that something bad will happen)
195	O	O	O	Nervousness causing loss of appetite
196	O	O	O	Nervousness with indigestion
197	O	O	O	Gastritis
198	O	O	O	Forgetfulness
199	O	O	O	Thinning hair
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

STANDARD PROCESS ***STRESS ASSESS***™

How well do you think you are handling stress? This assessment will help you and your health care professional design a personalized program to support your stress response and well-being.

Have you experienced any significant life events or changes in the last three months (illness, injury, job change, new baby, marriage, divorce, extreme training for a sporting event, major project at work, etc.)? If so, please list: _____

Hours of sleep each night:	Hours exercised per week:	Alcoholic drinks per week: (1 drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)	Meals eaten out per week:
3-4 5-6 7-8 9+	0 1-2 3-5 6+	0 1-2 3-7 8+	0 1-2 3-5 6+

Do you have any downtime or participate in quiet mindfulness activities? (Pilates, yoga, meditation, quiet walks, personal hobbies) **Yes** **No**

Please answer the following questions based on your experience within the last month.	Not at All	Little Bit	Somewhat	Quite a Bit	Very Much
1. How stressful would you say your life is?	1	2	3	4	5
2. Dealing with daily stresses is negatively affecting my daily tasks.	1	2	3	4	5
3. I have a high intake of sugar and/or processed foods.	1	2	3	4	5
4. I feel worn down and/or burnt out.	1	2	3	4	5
5. I need caffeine or other energy drinks in the morning or afternoon to give me energy.	1	2	3	4	5
6. I seem to have lower than usual energy during the day.	1	2	3	4	5
7. I experience body aches and pains.	1	2	3	4	5
8. I have periods of low moods.	1	2	3	4	5
9. I feel more irritable.	1	2	3	4	5
10. My weight and metabolism have changed.	1	2	3	4	5
11. I can't seem to focus or concentrate.	1	2	3	4	5
12. I have feelings of anxiousness.	1	2	3	4	5
13. I feel totally exhausted most of the day and only have a few productive hours.	1	2	3	4	5
14. I find myself pushing through fatigue to get things done.	1	2	3	4	5
15. I seem to be sleeping a lot but never feel quite rested. I wake up feeling tired.	1	2	3	4	5
16. I have difficulty getting to sleep and/or wake up in the middle of the night.	1	2	3	4	5
17. I experience strong cravings for sweet or salty foods.	1	2	3	4	5
18. I feel overwhelmed with daily tasks and all that is on my plate.	1	2	3	4	5
19. I have a low sex drive.	1	2	3	4	5
20. I am unable to enjoy socializing with family and/or friends.	1	2	3	4	5

Add up your total score and mark where you fall on the stress scale below. **Total:** _____

Low Stress **High Stress**

20 40 60 80 100

Stress is fairly well managed in your life. It may be important to support your body to continue its healthy response.

Your body's response to stress may be getting in the way of normal activities quite frequently, leaving you feeling depleted. Consult your health care professional for an individualized program to achieve your health goals.

You may have experienced prolonged stress, and your body's stress response can no longer adapt or successfully cope. Consult your health care professional for targeted support and strategies for improvement.

Name: _____ **Date:** _____

Standard Process®
WHOLE FOOD NUTRIENT SOLUTIONS

Dr. Katie Sokolski, Chiropractor
Healing Arts Chiropractic
187 40th Street Way
Oakland, CA 94611
Ph: 510-356-7832
Fax: 510-350-8522
dr.sokolski@gmail.com

PERMISSION & AUTHORIZATION FORM

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Healing Arts Chiropractic to perform a clinical nutrition health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **clinical nutrition is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that clinical nutrition is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of your clinical nutrition program or any natural health, nutritional or dietary programs recommended, but rather I understand that clinical nutrition is a means by which the body's natural reflexes can be used as an aid to determine possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Signed: _____

(if minor, signature of parent or guardian required)

Witness: _____

Informed Consent for Chiropractic Treatment of your Pain

The nature of your chiropractic treatment: The doctor will use her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice; exercise; hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral disks, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about the possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name	Signature	Date

Witness Name	Signature	Date

Cancellation Policy

Healing Arts Chiropractic requires a 24 hour cancellation/rescheduling notice for all appointments. Patients who miss, cancel or reschedule their appointments within 24 hours of the original scheduled time will be charged $35. We have an automated email notification system to help you keep track and to remind you of your appointments. If you have a preference for another form of notification/reminder, please work out the details with our office manager. Thank you for understanding that a 24 hour notice will open the schedule to our waitlist patients who can fill the time slot.

By signing below, I acknowledge that I have read the above cancellation policy and agree to the stated terms.

Print Name

Signature