steinchiropractic
NECK & BACK | PAIN RELIEF

HEALTH HISTORY FORM

First Name _____ Last Name _____ DOB _____ ☐ M ☐ F Age _____

Address _____ City _____ State _____ Zip _____

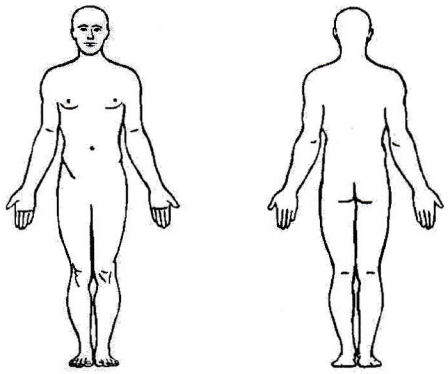
Phone _____ Email _____

How did you hear about us? _____ SS# _____

Have you had Chiropractic care before? ☐ Yes ☐ No Height _____ Weight _____

Reason for today's visit? _____

When did this begin? _____ Have you had this or a similar condition in the past? ☐ Yes ☐ No



☐ Headaches	☐ Fused/Fixated Joints	☐ Cancer
☐ Migraines	☐ Herniated Disk	☐ Stroke
☐ Neck Pain/Stiffness	☐ Seizure Disorders	☐ Pacemaker
☐ Hip Pain/Stiffness	☐ Joint Replacement	☐ Hepatitis
☐ Shoulder Pain/Stiffness	☐ Osteopenia	☐ Tuberculosis
☐ Low Back Pain/Stiffness	☐ Osteoporosis	☐ Hernia
☐ Upper Back Pain/ Stiffness	☐ AIDS/HIV	
☐ Back/Spine Condition	☐ Tumors	

Other _____

Initial here _____ If you do not have any of the following conditions

☐ Recent Major Trauma _____

☐ Spinal Surgery Date _____ Spine Level _____

☐ Spinal Fracture Date _____ Spine Level _____

☐ Spinal Dislocation Date _____ Spine Level _____

☐ Spinal Tumor Date _____ Spine Level _____

☐ Spinal Infection Date _____ Spine Level _____

☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis ☐ Myelopathy

☐ Vertebrobasilar Insufficiency Syndrome(VBI) ☐ Arthropathies

☐ Spinal Bone Demineralization ☐ Spinal Joint Instability

☐ Major Artery Aneurysm near the Spine: Where _____

☐ Other health history issues _____

_____

Int _____ I do not have a current Workers Compensation Case, Personal Injury Case or Car Accident Case.

Int _____ I am not Medicare eligible and I understand that Medicare will not be billed.

Int _____ I understand that some chiropractors use x-rays and diagnostic testing to rule out medical conditions. I do not wish to have either done for personal reasons.

Int _____ I direct Yosef Stein, D.C. to perform only the minimal evaluation procedures needed to find Vertebral Subluxations.

Int _____ I understand my patient visits will be stored using an electronic health record it is my responsibility to check in for every visit and to notify Yosef Stein, D.C. if I am unable to do so.

Name of Patient _____ Date _____

Patient or Legal Guardian Signature _____

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INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from Stein Chiropractic.

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis.

Patient's Name _____

Patient/Legal Guardian Signature _____ Date _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

Acknowledgement of Receipt of "Notice of Privacy Practices"

I, _____ hereby acknowledge that I have been offered a copy of this chiropractic practice's "Notice of Privacy Practices." I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended notice of privacy practices.

_____ _____

Signature Date