

Informed Consent to Chiropractic

At Hill Country Health and Wellness

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Privacy Notification: We have an Open Concept Office which means some conversations may be overheard by others. If a confidential conversation is needed with the provider, we can arrange to use one of our Private Offices.

Unusual risks:

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date

**Authorization to Use or Disclose (Release) Health Information
that Identifies You for a Research Study**

If you sign this document, you give permission to all health care providers and support staff at Hill Country Health and Wellness Center to use or disclose (release) your health information that identifies you for the research study described below:

Health Outcomes for Patients Receiving Chiropractic Care

The health information that we may use or disclose (release) for this research includes

All information in a medical record, results of physical examinations, medical history, lab tests, completed health questionnaires, or certain health information indicating or relating to a particular condition.

The health information listed above may be used by and/or disclosed (released) to:

- All health care providers, researchers and their staff.

Hill Country Health and Wellness Center is required by law to protect your health information. By signing this document, you authorize Hill Country Health and Wellness Center to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

- No publication or public presentation about the research described above will reveal your identity without another authorization from you.
- If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

Please note that Hill Country Community Health and Wellness Center may not condition (withhold or refuse) treating you on whether you sign this Authorization.

Please note that you may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, Hill Country Health and Wellness Center may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: Hill Country Health and Wellness Center, 29632 Hwy 299 E, Round Mountain CA 96084

This Authorization does not have an expiration date.

Signature of participant or participant's
personal representative

Date

Printed name of participant or
participant's personal representative

If applicable, a description of the
personal representative's authority to
sign for the participant

Patient _____ Today's Date _____

Can you describe your condition in your own words?:

Would you describe this problem as chronic? Y or N

I have had this pain for _____ days, weeks, months, years.

What were you doing when this started?

The pain is sharp, dull, stabbing, aching, burning, other _____

This pain hurts me 0-25%, 25-50%, 50-75%, 75-100% of the day

Does this pain radiate to other areas of your body? Y or N

What makes this pain better? Rest, Ice, Advil, Tylenol, Aleve, Cannabis, Prescription Meds, Massage, Stretching, Other _____, "Nothing seems to stop the pain"

What makes this pain worse? Movement, Too Much Rest, Lifting, Bending my spine, Twisting my spine, Other _____

If you have had this exact pain in the past, what have you done for it?

Do you experience headaches on a regular basis? Yes or No

If Yes, How often? _____ What type of headaches? _____

Have you been in a motor vehicle accident? Yes or No

Have you ever had a concussion or knocked unconscious? Yes or No

Have you ever fractured any bone in your body? Yes or No

Have you utilized chiropractic in the past? Yes or No

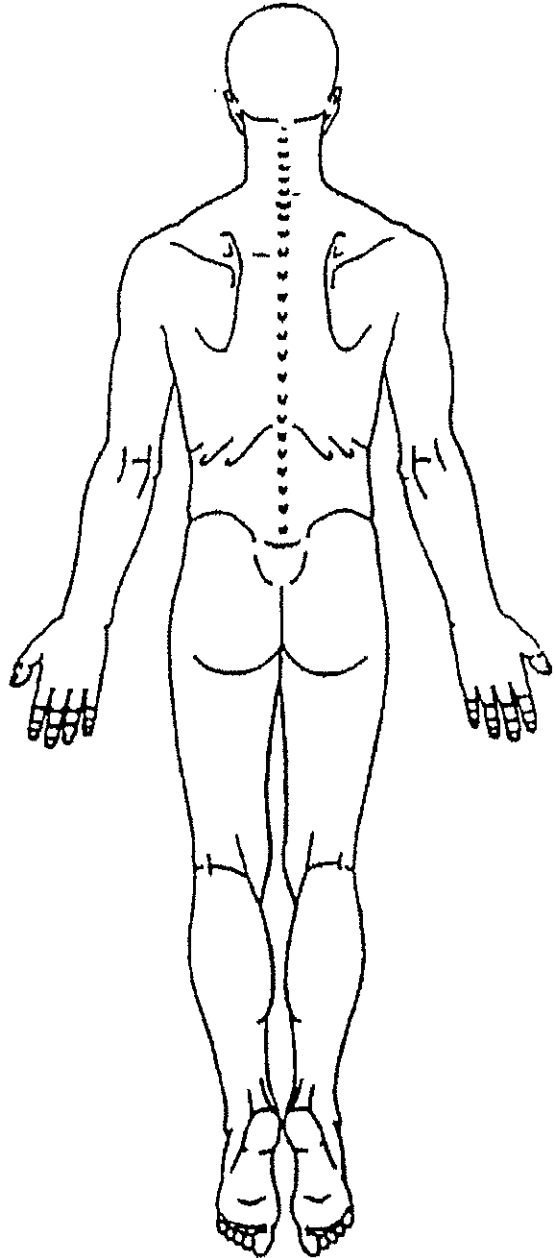
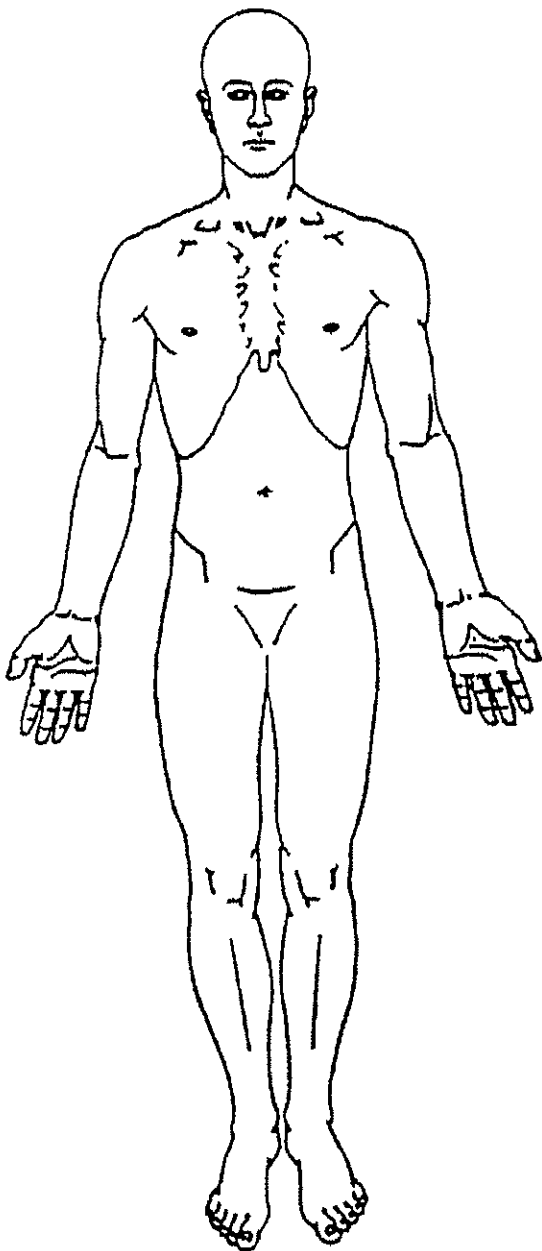
Use this space to write about anything else you would like to discuss with Dr. Rob.

Name: _____

Date: _____

How long have you had neck/back pain _____ years _____ months _____ days

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



Quadruple Visual Analogue Scale (QVAS)

Patient's Name _____

Date _____

Instructions: Please Circle the Number that best describes the question that is being asked.
Remember, a low number means there is less pain; a higher number means there is more pain.

1. Rate your pain RIGHT NOW

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2. Rate you TYPICAL OR AVERAGE pain

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

3. Rate your pain AT ITS BEST (how close to a "0" does your pain get?)

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4. Rate your pain AT ITS WORST (how close to a "10" does your pain get?)

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

Symptoms

Name _____

Date _____

Please fill in all the symptoms you currently have.

A) Orthopedic & Musculoskeletal Symptoms

- "Clunk" sound with neck movements
- Neck pain
- Upper back pain
- Lower back pain
- Shoulder pain L R
- Upper arm pain L R
- Elbow pain L R
- Forearm pain L R
- Wrist pain L R
- Hand pain L R
- Hip pain L R
- Upper leg pain L R
- Knee pain L R
- Lower leg pain L R
- Ankle pain L R
- Foot pain L R
- Jaw pain
- Clicking in jaw
- Painful chewing
- Face pain
- Chest pain
- Stomach pain
- Bruising at _____
- Other symptoms _____

B) Neurological Symptoms

- Numb/Tingling Arm/Hand L R
- Numb/Tingling Leg/Foot L R
- Weakness Arm/Hand L R
- Weakness Leg/Foot L R

C) Symptoms Associated with Injuries

- Stiffness or limited movement in joint(s)
- Headaches
- Muscle spasms/sore muscles
- Dizziness, lightheaded, woozy feelings
- Visual disturbances or vision change
- Sleep changes/disruption of pattern
- Pain Radiates from one place to another
- Anxiety or nervous when driving
- Irregular Heartbeat or uneven pulse
- Feeling Depressed about things

Patient Signature _____