About You

Deines Chiropractic
307-673-5075
1821 S. Sheridan Ave
Unit A
Sheridan, WY 82801

Legal Name: _____

Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Birthdate: __/__/____ Age: _____ Gender: M F Significant Other: _____

Who referred you? _____ Employer _____ Type of Work _____

Emergency Contact _____ Phone # _____

Have you been to a chiropractor before? ☐ Yes ☐ No

If yes, how long ago? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child
- I authorize Deines Chiropractic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services, all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card

_____ _____

Patient/Parent Signature (This represents a long term authorization for all occasions of service) Date

☐ X-ray okay for minor

Present Complaints

1. _____ How long has this been an issue? _____

IS IT: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in the evening ☐ Pain radiates to _____

2. _____ How long has this been an issue? _____

IS IT: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in the evening ☐ Pain radiates to _____

How motivated are you to address the root cause of your issues?

0 1 2 3 4 5 6 7 8 9 10

Not Motivated — Very Motivated

What is your current condition keeping you from?

What makes it better? _____

What makes it worse? _____

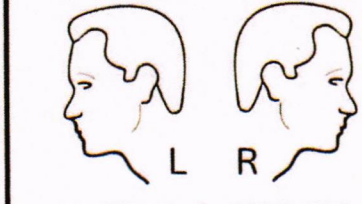
What doctors have you seen for this? _____

Type of Treatment: _____

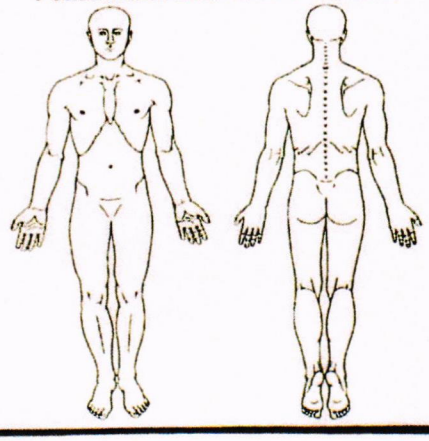
Results: _____

Are you pregnant?

☐ Yes ☐ No



Pease mark all areas of concern



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GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:**_____
2. **Please list all doctors you are currently seeing:** _____
3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

4. **List any past auto collisions** _____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?** _____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____
8. **Please list any past hospitalizations and surgeries:** _____

FAMILY HISTORY

Father's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Mother's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Is there any other family history you want us to know?_____

Functional Reading Index

In order to properly assess your condition, we must understand how much your current spinal condition has affected your ability to manage everyday activities. Please circle the number which most closely describes your condition right now.

Pain Intensity

0	1	2	3	4
No Pain	Mild	Moderate	Severe	Worst Possible

Sleeping

0	1	2	3	4
Perfect Sleep	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disturbed

Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; No restrictions	Mild pain; No restrictions	Moderate pain; Need to go slowly	Moderate pain; Need some assistance	Severe pain; Need 100% help

Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

Work

0	1	2	3	4
Can do usual work and more	Can do usual work, no extra	Can do 50 % of usual work	Can do 25% of usual work	Cannot work

Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activites	Cannot do any activities

Frequency of pain

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50 % of the day	Frequent pain 75% of the day	Constant pain 100% of the day

Lifting

0	1	2	3	4
No pain	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Walking

0	1	2	3	4
No pain; Any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

Standing

0	1	2	3	4
No pain after Several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____ **DOB:**___/___/_____

Signature_____**Date:**___/___/_____

Total: _____

DEINES
CHIROPRACTIC CLINIC

For our new patients at Deines Chiropractic, it is important for us to get a baseline examination and diagnostic work so that we can accurately find the cause of the problem. We generously provide these services for our new patients at a discounted rate because we value the members of our community and want each person who comes through our doors to receive the best care possible.

Your appointment today may include the following:

- **Thermo-Scan**
- **Muscle Activity Test**
- **X-Rays (Cervical & Lumbar)**
- **New Patient Exam**
- **Chiropractic Adjustment**

A $400 total value for ONLY $71

Please check the appropriate box: Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Print Name: _____

Initials: _____ Date: _____

DEINES
CHIROPRACTIC CLINIC

Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. 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. I will use that procedure to treat you. I may use my hands or a mechanical instrument 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/Examination/Treatment As part of the analysis, examination, and treatment, you are consenting to the following procedures: __Spinal manipulative therapy __palpation __vital signs __Range of motion testing __orthopedic testing __basic neurological testing __muscle strength testing __postural analysis testing __hot/cold therapy __EMS __radiographic studies __decompression therapy __radial pressure wave therapy __other

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, dislocations, 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 result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. 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 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 pain-killers
- Hospitalization or Surgery

If you chose to use one of the above noted "other treatment" 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 (MINOR)

I hereby request and authorize Dr. Deines to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. 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 health care services for the minor child 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.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had any 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 that treatment.

_____ _____

Signature Date

_____ _____

Patient's Name (Print) Signature of Parent or Guardian (if a minor)