Tenold Chiropractic
HEALTH & REHAB CLINIC

UPDATE FORM

Todays Date: _____

First Name: _____ MI: _____ Last: _____

If insurance or billing info has changed since last appointment, please provide the front desk with updated info.

Is this visit related to an Auto Accident: Yes / No Is this visit related to Work Injury: Yes / No

(Please complete this section if information has changed since last appt)

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

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Employer/Occupation: _____ Work Status: full / part / retired / unemployed

Marital Status: single / married / divorced / widowed Spouse's Name: _____

ABOUT YOUR HEALTH…

In order of importance, what conditions are you most interested in correcting?

1. _____ 2. _____ 3. _____

In order of severity, what functions are you unable to perform, i.e. sitting, bending, etc?

1. _____ 2. _____ 3. _____

What make your condition worse? _____ How long have you been in pain? _____

Is your condition getting: Worse / Better Is it: Constant or Does it Come and Go

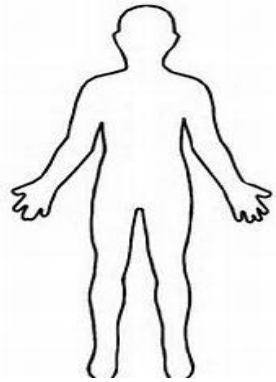
Is your condition interfering with: Work / Daily Routine / Sleep / Other: _____

Have you been in an auto or work accident: In the past 12 months: Yes / No One to five yrs: Yes / No

Over 5 years: Yes / No Never

MARK THE APPROPIATE SENSATION…

FRONT



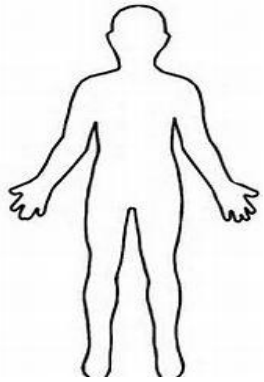
Numbness: >>>

Pins & Needles: ooo

Burning: xxx

Stabbing: ///

Aching: (((



BACK

CURRENT MEDICAL HISTORY…

Do you have allergies to any drugs: Yes / No Please list: _____

Current medication(s) or supplement(s)… List all medications and/or supplements you are currently taking, along with the reason you were prescribed/recommended them. Ie: atenolol-high blood pressure ( ) None

_____

_____

Currently wearing: Heel Lift: Yes / No Insoles: Yes / No Arch Supports: Yes / No

Currently pregnant: Yes / No If yes, under care of: _____

Please list any changes to family history since last visit: _____

PERSONAL HABITS...Please circle what is appropriate

Alcohol	_____ per day / week / month	Coffee, tea (decaf or reg)	_____ per day / week / month
Water	_____ glasses per day	Soda (reg / diet / decaf)	_____ per day / week / month
Exercise	_____ hours per day / week	Drugs-recreational	_____ per day / week / month
Sleep	_____ hours per night	Tobacco	_____ per day / week / month / former / never

INFORMED CONSENT TO CHIROPRACTIC TREATMENT / MEDICAL RELEASE

The Nature of Chiropractic Treatment : The doctor will use his/her hands or a mechanical device in order to move your joints . You may fee a "click"/"pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement to the joint. Various ancillary procedures, such as hot/cold packs , electric muscle stimulation, therapeutic ultrasound, or traction may also be used. **Possible Risk**: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications couldconceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints , or injury to intervertebral discs nerves,or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures couldcould produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medicaldoctors and chiropractors. Research and scientific evidence does not establish a cause and relationships between chiropractic treatmentrelationship between chiropractic treatment and the occurrence of stroke, rather, recent studies indicate that patients may beconsulting medical doctors and chiropractors when they are in the early stages of stroke. The possibility of such injuries occuringin association with upper cervical adjustment is extremely remote. If any unusual risks are determined by the treating doctor for yourspecif case, the doctor will discuss these risks with you prior to starting treatment. **Probability of Risks Occurring** : The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often then complications from taking a single aspirin tablet.

Other treatment options which could be considered may include the following: **1. *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. **2. *Medicalcare* ,** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable sideeffects and patient dependence in a significant number of cases. 3. ***Hospitalization*** in conjunction with medical care adds risks ofexposure to virulent communicable disease in a number of cases. 4. ***Surgery*** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as 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 include chronic pain cycles. It is quite probable that delay of treatmentwill complicate the condition and make future rehabilitation more difficult.

Medical Release: I authorize the release of any medical or other information necessary to process billing claims. I understand and agree any amount authorized to be paid directly to Tenold Chiropractic will be credited to my account upon receipt. I understand in the event my responsible party/insurance company/etc. does not cover the full amount, I will pay my account balance in full.

I have read the above and have had the opportunity to have any questions answered to my satifaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo treatment and hereby give my full consent to treatment as wel to treatment as well as the release of necessary medical information .

Signature: _____ **Date:** _____