

Frequency: Constant(76%-100%) / Frequent(51%-75%) / Intermittently(26%-50%) / Occasionally(0%-25%)

Onset: How long ago did the symptoms start? _____

Quality: Describe your pain: __aching __burning __cramping __deep __dull __numb __radiating __sharp
__shooting __sore __stabbing __stiff __swelling __tight __tingling __throbbing

What caused the problem? _____

Is the pain worse a specific time of day? Morning / Afternoon / Evening / Night

Do you have any old/new scars? If so, where are they located? _____

Aggravating Factors: What makes the problems worse?

- | | | |
|---|---|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Caring for children | <input type="checkbox"/> Lying down | <input type="checkbox"/> Taking a deep breath |
| <input type="checkbox"/> Cleaning/cooking | <input type="checkbox"/> Massage | <input type="checkbox"/> Turning |
| <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Pulling | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Carrying things | <input type="checkbox"/> Pushing | <input type="checkbox"/> Transitioning from sitting to standing |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Running | <input type="checkbox"/> Using phone/computer |
| <input type="checkbox"/> Daily hygiene activities | <input type="checkbox"/> Sex | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Shopping | <input type="checkbox"/> Working |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Sitting | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Yardwork |
| <input type="checkbox"/> Lying to sitting | <input type="checkbox"/> Sneezing | |
| <input type="checkbox"/> Lying to standing | <input type="checkbox"/> Social activities | |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Squatting | |
| <input type="checkbox"/> Housework | <input type="checkbox"/> Standing | |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Standing for a while | |
| <input type="checkbox"/> Jogging | <input type="checkbox"/> Stress | |

Relieving Factors: What makes the problem better?

- | | | |
|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Ice | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Bracing | <input type="checkbox"/> Lying | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Massage | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Medications | <input type="checkbox"/> Therapy |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Movement | <input type="checkbox"/> Walking |

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? __None __Medication __Surgery __Physical Therapy
__Chiropractic __Massage __Heat/Ice __Other _____

Energy Level: Good / Insufficient / Erratic

Sleep: Trouble falling asleep / Trouble staying asleep / Restful / Good sleep

Stress: None / Low / Moderate / Severe

Have you had any unexpected weight loss/gain in the last 6 months? Yes / No If yes, how much? _____

Do you smoke? __Never smoked __Current every day smoker __Current some day smoker __Former

Daily caffeine intake (cups): __None __1-3 __4-6 __7-10 __11-15 __16-20

Weekly alcoholic drinks (cups): __None __1-3 __4-6 __7-10 __11-15 __16-20

Do you exercise regularly? No / Light / Moderate / Heavy

Illnesses you have or have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump/Mass | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis/Osteopenia | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Pinched Nerve | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Prosthesis | |

Review of systems: Check all that apply

Musculoskeletal:

- None
- Arm/Hand pain
- Back pain
- Feet/Leg pain
- Hip pain
- Knee pain
- Lower back pain
- Mid/upper back pain
- Muscle/joint pain
- Neck pain
- Redness of joints
- Shoulder pain
- Stiffness
- Swelling of joints

Cardiovascular/Respiratory:

- None
- Chest pain
- Coughing up blood
- Coughing up phlegm
- Difficulty breathing
- Fainting
- Irregular heartbeat
- Palpitations
- Persistent coughing
- Shortness of breath
- Tightness in chest
- Wheezing

Head/Neck:

- None
- Dizziness
- Facial pain
- Grinding teeth
- Headache/Migraines
- Head injury
- Jaw clicks
- Lumps/swollen glands

Eyes:

- None
- Blurred vision
- Burning
- Cataracts
- Double vision
- Dryness
- Flashing lights
- Glasses/Contacts
- Glaucoma
- Itching
- Redness
- Specks

Ears:

- None
- Ear infections
- Buzzing in ears
- Poor balance
- Decreased hearing
- Poor hearing
- Drainage
- Ringing in ears
- Earache

Nose:

- None
- Allergies
- Blocked sinuses
- Discharge
- Excessive mucus
- Hay fever
- Itching
- Nose bleeds
- Sinus pressure

Endocrine:

- None
- Heat/Cold Intolerance
- Sweating

Throat/Mouth

- None
- Bleeding
- Braces
- Dentures
- Difficulty swallowing
- Dry mouth
- Hoarseness
- Non healing sores
- Sore throat
- Thrush
- Tooth pain

Urinary:

- None
- Blood in urine
- Burning or pain
- Difficulty/frequent urinating
- Frequent UTI's
- Incontinence
- Kidney stones
- Urgency
- Water retention

Gastrointestinal:

- None
- Change in appetite
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Rectal bleeding
- Change in bowels

Vascular/Hematologic:

- None
- Calf pain with walking
- Cold hands/feet
- Ease of bleeding/bruising
- Leg cramping

Neurologic:

- None
- Seizures
- Easily angered
- Fainting
- Frequent crying
- Memory confusion
- Neuropathy
- Numbness
- Poor concentration
- Tingling
- Tremors
- Weakness

Psychiatric:

- None
- Anxiety
- Depression
- Memory loss
- Nervousness
- Stress
- Suicidal thoughts

Female:

- Pregnant Yes / No
- Number of pregnancies _____
- Number of deliveries _____
- Number of cesareans _____
- Operations: Cervix Uterus Ovaries
- Clotting
- Dark color
- Discharge
- Heavy/light bleeding
- Hot flashes
- Irregular periods
- Itching/rash
- Leg cramps
- Little/no sex drive
- Menstrual cramps
- Miscarriage
- Missed periods
- Mood swings
- Pain with sex
- Painful breasts
- STD's/infections
- Vaginal sores/dryness
- Water retention

Male:

- Discharge
- Erectile dysfunction
- Hernia
- Impotence
- Low sex drive
- Masses/pain
- Painful urination
- Pain with sex
- Prostate problems
- Sores
- STD's

Informed Consent for Chiropractic\Physiotherapy\Needle Acupuncture Treatment

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. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used. 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. The ancillary procedures could produce skin irritation, burns or minor complications. 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". 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.

Please take time to read this form, which will provide you with some basic knowledge about needle acupuncture treatment. While receiving needle acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of needle acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness. Everyone responds to treatment differently therefore; we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. By signing this informed consent, you (the patient) acknowledged that you have read the information above carefully and are giving consent for treatment. Single-use, sterile, disposable needles are used in this clinic

HIPPA Notice of Privacy Practices

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

No Call/No Show Notice

We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Brooks and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Progressive Chiropractic sends text message and email reminders the day before your appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. If you do not cancel or reschedule your appointment, you will be charged a \$25 "no-show" fee. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

Patient/Guardian Signature _____ Date _____