

Name: _____ Gender (circle): M F Birthdate: _____

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

Phone: Home: _____ Cell: _____ Office: _____

Email: _____

Marital Status (circle): Single Married Other Name of Partner: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Medical Doctor: _____ Last Visit: _____

Have you ever seen a Chiropractor?: No Yes (Who?): _____

How did you hear about our office? _____

Insurance:

Employer: _____ Occupation: _____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Health Plan: _____ Subscriber ID: _____ Group Number: _____

Authorization and Release:

• I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. **Initials:** _____

• I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. **Initials:** _____

• I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **Initials:** _____

Late Charges:

If I do not pay the entire new balance with 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In care of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Initials: _____

Other Fees:

We realize emergencies come up, but if you need to cancel an appointment for any reason, we request that you make every attempt to give us 24 hours notice. By giving adequate notice of cancellation you allow us to help others more quickly. If you do not contact our office prior to your appointment you will be billed a missed appointment fee of \$50. For any returned checks there will be a charge of a \$35 return check fee.

Initials: _____

Consent to Treat a Minor:

As parent or legal guardian, I have the authority to authorize and do hereby grant the Chiropractor at ASCST to administer chiropractic care as she deems necessary to my son/daughter/ward.

Initials: _____

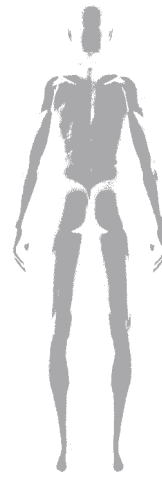
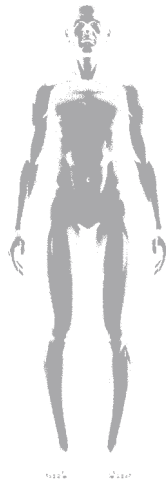
Signature: _____ **Date:** _____

What services are you interested in (circle): Active Release Graston Chiropractic Kinesiotape

Involved Areas (circle):

Height: _____

Weight: _____



What is the reason for your appointment? _____

When did this condition begin? _____

Has your condition been getting (circle): Better Worse Same

Have you ever experienced anything like this before? _____

How did this happen (circle): Sudden Slow Gradual

Due to (circle): Car Accident Work Accident Injury Sickness/Illness Unknown

What does this complaint feel like (circle all that apply):

- Ache Stiff Stabbing Sharp Shooting Throbbing
Tingling Weak Burning Numb Swelling Dull

Do you feel the sensation/pain anywhere else? No Yes (explain): _____

Does coughing or sneezing affect your condition? No Yes (explain): _____

Rate your pain on a scale of 0-10 (0 no pain, 10 is the worst pain imaginable):

At worst: _____

On Average: _____

Right now: _____

Do you feel this sensation (circle): Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Comes and Goes (0-25%)

How long does this sensation last? On average: _____

When bad: _____

When is your condition more pronounced (circle): Morning Afternoon Evening At Night With Activity

What makes your condition feel worse? _____

What makes your condition feel better? _____

In the space provided please enter "C" if you currently or "P" if you have ever had this problem.

General

- ___ Weight loss/gain
- ___ Allergies
- ___ Bleeding problem
- ___ Anemia
- ___ Diabetes
- ___ Cancer
- ___ Thyroid disease
- ___ Alcoholism
- ___ Drug abuse
- ___ HIV risk factor

Eye, Ear Nose & Throat

- ___ Poor vision
- ___ Loss of vision
- ___ Pain in eyes
- ___ Deafness/difficulty hearing
- ___ Nosebleeds
- ___ Sinus problems
- ___ Dental problems
- ___ Hoarseness
- ___ Tonsillectomy

Cardiovascular

- ___ Irregular heart beat
- ___ Pain over heart
- ___ High blood pressure
- ___ Previous heart trouble
- ___ Myocardial infarction
- ___ Ankle Swelling
- ___ Varicose Veins
- ___ Rheumatic fever
- ___ Stroke

Skin

- ___ Itching
- ___ Bruises easily
- ___ Changes in mole(s)
- ___ Skin Cancer

Health Habits

- ___ Smoking- current
- ___ Smoking- past
- ___ Drinking
- ___ Recreational drug use

Exercise

- ___ None
- ___ 1-2x/week
- ___ 3-5x/week
- ___ 6-7x/week

Nutrition (describe): _____

Respiratory

- ___ Difficulty breathing
- ___ Chronic cough
- ___ Spiting phlegm
- ___ Spitting blood
- ___ Wheezing/Asthma
- ___ Pneumonia
- ___ Tuberculosis

Genitourinary

- ___ Frequent urination
- ___ Painful urination
- ___ Blood in Urine
- ___ Kidney Disease
- ___ Urinary infection
- ___ Inability to control urine
- ___ Difficulty starting urine flow
- Get up ___ times/night to urinate
- ___ Breast lump or pain
- ___ Venereal Disease
- ___ Sexual difficulty

Neurologic

- ___ Weakness
- ___ Twitching
- ___ Tremors
- ___ Headache
- ___ Dizziness/Vertigo
- ___ Epilepsy
- ___ Numbness/tingling
- ___ Arm/leg pain
- ___ Mental Disorder
- ___ Partial or complete paralysis

Other

- ___ Tropical infection
- ___ Parasitic Infection

Men Only

- ___ Testicular Pain
- ___ Prostate Problems

Women Only

- ___ Live births
- ___ Miscarriage
- ___ Painful Period
- ___ Excessive flow
- ___ Irregular cycle
- ___ Hot flashes

Date of last period: _____

Date of last PAP: _____

Date of last mammogram: _____

Gastrointestinal

- ___ Poor appetite
- ___ Poor digestion
- ___ Difficulty swallowing
- ___ Vomiting blood
- ___ Pain over abdomen
- ___ Ulcer
- ___ Bloody stool
- ___ Liver problems
- ___ Gallbladder problems
- ___ Jaundice
- ___ Hernia
- ___ Loss of bowel control
- ___ Diarrhea
- ___ Constipation
- ___ Hemorrhoids
- ___ Appendicitis

Musculoskeletal

- ___ Neck Stiffness/pain
- ___ Pain between shoulders
- ___ Low back pain
- ___ Swollen joints
- ___ Painful joints
- ___ Muscle aches/soreness
- ___ Spinal curvature
- ___ Arthritis
- ___ Osteoporosis
- ___ Slipped/herniated disc

Family History

- ___ Diabetes
- ___ Thyroid Disease
- ___ Kidneys disease
- ___ High Blood Pressure
- ___ Heart Disease
- ___ Cancer
- ___ Epilepsy
- ___ Stroke
- ___ Gout
- ___ Allergies
- ___ Blood disease
- ___ Other

Medication

Prescription (list): _____

Vitamins/supplements (list): _____

I, _____ the undersigned, have voluntarily requested that Dr. Natasha Whittaker Ayers assist me in the management of my health concerns. I have understood and agreed to all policies and terms provided in the Office Policies and Procedures. I understand that Dr. Whittaker Ayers is a chiropractor and that her services are not to be construed or serve as a substitute for standard medical care. Dr. Whittaker Ayers recommends that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Exercise and nutritional counseling may also be used.

Although spinal manipulation/adjustment is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Active Release Technique and Graston technique may occasionally leave slight bruising and tenderness.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Whittaker Ayers if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

A thorough health history and tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results: I also understand that there are beneficial effects associated with these treatments procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor's choosing.

Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of great value, but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks or refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I have read and or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **PRIOR TO MY SIGNING THIS CONSENT FORM**. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Signature : _____

Witness : _____

Date : _____