PATIENT INFORMATION

Patient ID (Keytag Number): ____________________

First Name: ____________________ Last Name: ____________________

Sex: ☐ M ☐ F   Date of Birth: ____/____/____   Age: ________

1st Phone ____________________ ☐ W ☐ H ☐ C   2nd Phone ____________________ ☐ W ☐ H ☐ C

Email ____________________

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Home Address: ____________________

City: ____________________ State: ________ Zip Code: ________

Employer: ____________________

Work Address: ____________________

City: ____________________ State: ________ Zip Code: ________

Emergency Contact: ____________________ Phone: ____________________ ☐ W ☐ H ☐ C

Are you Medicare Eligible? ☐ Yes ☐ No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

Will you use this location from your:: ☐ Home ☐ Office ☐ or Both?

Approximately, how far did you travel to get here today? ☐ 0-3 miles ☐ 3-5 miles ☐ 5-10 miles ☐ 10+ miles

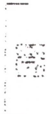
Approximately, how long did it take you to get here today? ☐ 0-5 mins. ☐ 6-10 mins. ☐ 11-15 mins. ☐ 15+ mins.

How did you hear about Cashel Chiropractic?

____

If you were referred by someone please tell us who so we may thank them. Referral: ____________________

I AGREE that Cashel Chiropractic and Associates, can email me at the email address above, or call or text message me at the 1st phone number above, even if I am on a federal or state do not call registry for any purpose, including marketing. Message and data rates may apply. I agree that the calls and text messages may be generated using an automatic telephone dialing system and many contain pre-recorded or artificial voice messages. I understand that consenting to receive calls or texts is not required to receive this service. I also understand that by signing this form, I represent that I am the wireless subscriber or customary user with respect to the wireless number(s) provided, and that I have the authority to provide the informed consent to receive that calls and text messages.



____________________ ____________________
(Patient or Legal Guardian Signature) (Date)

CASHEL CHIROPRACTIC

PATIENT HISTORY

Name ______________________ Age: ________ Date of Birth: ______________ Gender: ☐ M ☐ F

Height: _____ft._____in. Weight: ________lbs. Occupation: ______________________ For how long?______yrs.___ mos.

1. Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? ______________________

2. Reason for today's visit: ☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other

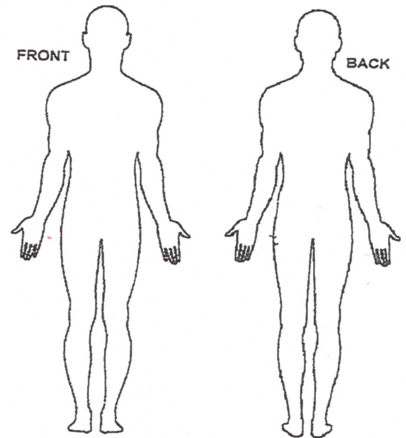
____

3a. When did your complaint(s) first begin? ______________________ 3b. Today, is the condition: ☐ Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: ______________________

4. Where is/are your area(s) of complaint today? Check all that apply		Rate pain and discomfort between 1-10 (1 = minimal, 10 = severe)	Check the Type of Complaint							Frequency	
			Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed/ swollen	Constant	Intermittent
	Headache/Migraine										
	Neck										
	Shoulder(s)										
	Arm(s)										
	Elbow(s)										
	Wrist(s)										
	Upper Back										
	Middle Back										
	Lower Back										
	Hip(s)										
	Sciatica										
	Knee(s)										
	Ankle(s)										

5. Use the figures below to place an "X" onany specific area(s) where you are experiencing pain, discomfort or limited range of motion.



6. Have you experienced this/these complaint(s) before? ☐ Yes ☐ No

If yes, when? ______________________

7. Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? ______________

For Clinic Use Only: BP:________/_______

8. Are you currently experiencing any of the following (If yes to any, please describe below): ☐ N/A

☐ Nausea or vomiting
☐ Rapid eye movement
☐ Numbness on one side of the face or body
☐ Fainting or lightheadedness
☐ Dizziness
☐ Difficulty walking
☐ Difficulty speaking
☐ Headache or neck pain
☐ Difficulty swallowing
☐ Double vision

____

9. Current prescriptions or over-the-counter medications: ______________________

PAST HISTORY: MUSCULOSKELE TAL CONDITIONS (please check all that apply): ☐ N/A

☐ Headaches/Migraines
☐ Neck Pain/Discomfort
☐ Shoulder Pain/Discomfort
☐ Upper Back Pain/Discomfort
☐ Middle Back Pain/Discomfort
☐ Low Back Pain/Discomfort
☐ Inflammation/Swelling; where: ______________________
☐ Hip Pain/Discomfort
☐ Sciatica
☐ Elbow Pain/Discomfort
☐ Wrist Pain/Discomfort
☐ Knee Pain/Discomfort
☐ Ankle Pain/Discomfort
☐ Arthritis
☐ Fused/Fixated Joints
☐ Herniated Disc
☐ Joint Replacement
☐ Osteoporosis
☐ Osteopenia

OTHER CONDITIONS: ☐ N/A

☐ Cancer
☐ Tumors
☐ Stroke
☐ Seizure Disorders
☐ High Blood Pressure
☐ Pacemaker
☐ Allergies
☐ Other ______________
☐ Heart Disease
☐ AIDS/HIV
☐ Diabetes
☐ Hepatitis
☐ Tuberculosis
☐ Hernia

10. Indicate if you have experienced any of the following and mark how recently

Surgeries? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months_______yrs.

No Accidents/Broken Bones? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months_______yrs.

Hospitalizations? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months_______yrs.

If yes to any, list and describe: ______________________

11. Family Health History: (check all that apply) ☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ N/A

____
(Patient or Legal Guardian Signature)

____
(Date)

CASHEL
CHIROPRACTIC

INFORMED CONSENT

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

i. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

ii. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.

iii. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, have had the opportunity to discuss, and/or will seek to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment. I acknowledge that I have read and understand the contents of this Intake Form and Informed Consent

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this______________________________day of____20______________________

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis*

***In applicable states, please initial after reading the statement, above. Patient initials________Doctor initials ______**

____
(Patient Printed Name)

____ ________________________________
(Patient or Legal Guardian Signature) (Date)

____ ________________________________
(Witness / Employee Signature) (Date)

TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS "WE", "OUR AND/OR "US" REFERS TO THE LEGAL OWNER AND OPERATOR OF THIS LOCATION. THESE TERMS OF ACCEPTANCE AND ALL DOCUMENTS BELOW ARE INCORPORATED INTO YOUR APPLICABLE PLAN.

EXPLANATION OF SERVICES

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore ,we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO:

- We provide the public with an affordable and convenient portal of entry to chiropractic care ofter resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a target movement were and when indicated by licensed Doctors of Chiropractic to improve motion of the body's spinal column and extremities and/or proper nerve function. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON'T DO / LIMITATION OF SERVICES

- We do not offer to treat and disease or condition other than joint dysfunctions associated with the spine and extremities.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities, and/or optimizing proper nerve function
- In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

At the patients's discretion, payment options are available after the Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them.

I,____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location or any other clinic under Cashel Chiropractic.

____ Date________________
(Patient Signature)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I,____ of ____________________________
(Parent or legal Guardian). (Child name)

Have read and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

____ Date ________________
(Parent or Legal Guardian Signature