The Chiropractic Connection
DOT Physicals | Drug Testing

Dr. Neil Szeryk
207 S. Allen Drive
Allen, TX 75013
972-390-9191

Informed Consent to Chiropractic Treatment

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of Chiropractic who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. You should note:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments.
- There have been alleged cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused, by spinal adjustment or chiropractic treatment.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment (including spinal adjustment) as well as contents of this consent. I am aware of these complications, and to minimize their occurrence I will take precautions. These precautions include but are not limited to: conducting a detailed clinical history & a comprehensive examination. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

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

Date: _____

Patient's Name: _____Witness's Name: _____

Patient's Signature: _____Witness's Signature: _____

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PERSONAL INFORMATION

Name _____ Date _____
Home Address_____ City_____ State ____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email Address _____
Contact Pref. H_ W_ C_ Email _____
Birth date ___/___/____ Age _____ SS # _____-_____-_____
Marital Status (circle one) Single Married Divorced Widowed
Number of Children and Ages _____
Employer _____ Occupation_____

SPOUSE'S INFORMATION

Name of Spouse_____ Employer _____
Spouse's Birth date _____ Spouse's S.S. #_____-_____-_____

OTHER INFORMATION

Emergency Contact _____ Relation _____ Phone_____
Whom may we thank for referring you?
_____
Have you ever been to a chiropractor? Yes_ No_ Who?_____
When? _____ If yes, were the results satisfactory? _____
Purpose of this appointment _____

PRIMARY CARE PHYSCIAN

Physician: _____ Phone: _____
May we update them on your condition? Yes _____ No _____

INSURANCE INFORMATION
If insured, please provide your insurance card to copy.
Relationship to insured Self____ *Spouse____ *Parent____
* If other than "Self" provide Name and Date of Birth of insured:
Name: _____ D.O.B _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the policyholder. I authorize this office to release any medical information and to complete any usual and customary reports to assist in collecting information from my insurance company. I understand that I am ultimately responsible for payment in full at this office.

Patient's Signature _____ Date _____

INJURY INFORMATION

Describe your major complaint _____

When did your problem begin? (specific date if possible) _____

How did your problem begin? _____

_____

What increases your pain? _____ decreases? _____

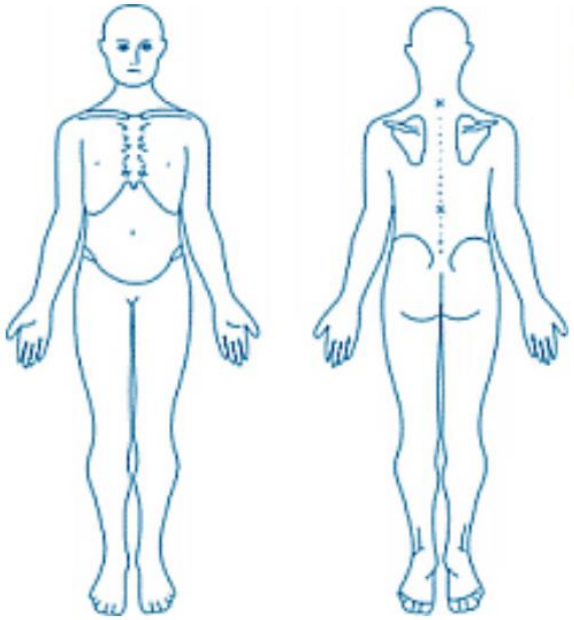
How many days a week do you experience pain/discomfort? _____ days

Are your symptoms ___Decreasing ___Not Changing ___Increasing

Symptoms are worse in the ___Morning ___Afternoon ___Evening ___Same all day

Has your daily activity changed because of your condition? If so, please explain.

No__ Yes_____



Please check the corresponding pain description and frequency for each area (1,2,3, etc) indicated on the diagram to the left.

Description	Area 1	2	3	4
Sharp pain				
Dull pain				
Ache				
Weak				
Throbbing				
Numb				
Shooting				
Gripping				
Burning				
Tingling				
Frequency				
Constant (76-100%)				
Frequent (51-75%)				
Intermittent (26-50%)				
Occasional (25% or less)				
Other				

Indicate your pain by circling your highest pain level and lowest pain level for each area indicated above.

AREAS

1 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

2 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

3 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

4 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

What treatments have you previously tried for this condition?

Physical Therapy ___ Chiropractic ___ Massage ___ Orthopedic ___ Family/Primary Doctor ___ Other _____

If so, please write name _____

Have you had Spinal X-Rays, MRI, CT SCAN? __No __Yes: Date(s) taken: _____

Area scan covered _____ _____ _____

Below please list all doctors you have seen since your accident/ onset of pain:

Name of doctors_____

_____

Condition(s) being treated:

_____

List all prescription, non-prescription medications and other supplements you take as well associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had including month and year:

_____

_____

_____

List any allergies: _____

Family History:_____

_____

Do you exercise: ____Yes ____No Hours per week?____

What activities:_____

Are you dieting? ____Yes ____No Since?_____

Do you smoke? ____Yes ____No Packs per day?____ How many years? ____

Do you drink alcoholic beverages? ____Yes ____No Drinks per day _____

For Women: Are you pregnant/nursing? ____Yes ____No How many weeks: _____

Last menstrual cycle: _____

Please circle all that apply below:

AIDS/HIV	Breast Lump	Emphysema	Measles	Stroke
Bleeding	Diabetes	Heart disease	Parkinson's	V.D
Depression	Gout	Liver disease	Rheumatoid	Arthritis
Gonorrhea	Kidney disease	Osteoporosis	Miscarriage	Cataracts
High Cholesterol	Mumps	Implants	Appendicitis	Goiter
Pacemaker	Prothesis	Typhoid	Herniated disc	Cancer
Prostate	Tumors	Anorexia	Fractures	Ulcers
Tuberculosis	Blood pressure	Bulimia	Hernia	M.S.
Chronic fatigue	Anemia	Epilepsy	Migraines	Thyroid
Allergy shots	Bronchitis	Hepatitis	Polio	Asthma
Chicken pox	Whooping cough	Glaucoma	Herpes	Mono
Pneumonia	Tonsillitis	Fibromyalgia	Other:	

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature: _____ Date: _____