CHIROPRACTIC INFORMED CONSENT TO TREAT

The State of Oregon requires that every patient be informed of the risks of, and the alternatives to, treatment prior to beginning said treatment. The following is the chiropractor's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

I understand that a Chiropractic evaluation and treatment may include, but is not limited to, history intake, physical examination, spinal and extremity manipulation, manual soft tissue therapy, instrument assisted soft tissue therapy, therapeutic exercise, and nutritional and lifestyle counseling.

Chiropractic examination and therapeutic procedures (including spinal and extremity manipulation, ultrasound, heat application, electrotherapy, manual muscle therapy and prescribed exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any medical or manual medical procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments is debated in the scientific peer reviewed literature. These complications include: injuries to the spinal discs, and rib/spinal fractures, and nerve injury. Serious complications are estimated to be in the range of 2 incidents per million for adjustments of the neck and 1 per million for adjustments for the low back. I agree to save, hold harmless, discharge and release the chiropractor from any and all liability, claims, causes of action, damages or demands in connection with Chiropractic care, Massage Therapy and/or Therapeutic Activities.

Please read the following statements carefully and initial.

_____ I affirm that I have answered all questions pertaining to medical conditions truthfully andwill update the practitioner of any changes in my health. I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the treating practitioner because it may affect care.

_____ I understand that I play an important role in my own health care. Just as the patient can choose to discontinue care at any time, Kwan Yin Healing Arts Center, Inc. reserves the right to terminate a doctor patient relationship if a patient is continually unable to comply with reasonable treatment plans.

If you have any further questions or concerns, please discuss with treating Practitioner prior to final signature.

By signing below, I hereby request and consent to the rendering of chiropractic treatment and other procedures within the scope of the practice of chiropractic in the State of Oregon. I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments from my present condition and any future conditions for which I seek treatment.

_____ _____ _____

Printed Name of Patient/Guardian/Guarantor **Signature of Patient/Guardian/Guarantor** **Date**

Health Concerns
Please list your concerns, in order of importance, including what brings you in today.

1 _____ 2 _____

3 _____ 4 _____

List all current and past long-term medications: _____

_____

Date problem began: _____ Is it getting Better ☐ Worse ☐ Staying the same ☐

It interferes with: Sitting ☐ Work ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐ Other ☐ _____

_____

Symptom Frequency: ☐ Constant (75%-100% of the time) ☐ Frequent (51%-75% of the time)

☐ Intermittent (26%-50% of the time) ☐ Occasional (0%-25% of the time)

When are symptoms the worst: ☐ morning ☐ afternoon ☐ evening ☐ do not change

Have you experienced this before, when, and how frequently? _____

_____

What decreases the symptoms: ☐ ice ☐ heat ☐ medication ☐ Stretching ☐ Nothing helps

☐ other: _____

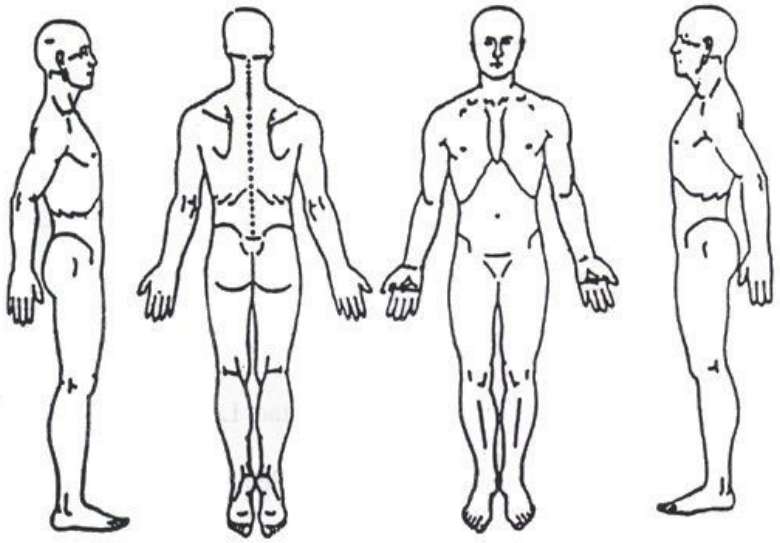
Please describe any other complaints: _____

_____

What are your goals of your treatment sessions? _____

_____

Mark current problem areas on the below picture:



Lifestyle

Tobacco use? Y ☐ N ☐ Past ☐ Quantity/type _____

Alcohol use? Y ☐ N ☐ Past ☐ Quantity/type _____

Drug use? Y ☐ N ☐ Past ☐ Quantity/type _____

Exercise? Y ☐ N ☐ Past ☐ Quantity/type _____

Caffeine? Y ☐ N ☐ Past ☐ Quantity/type _____

Alcohol use? Y ☐ N ☐ Past ☐ Quantity/type _____

Do you drink lots of water? Y ☐ N ☐ Past ☐ _____

Do you consider yourself to hold much stress? Y ☐ N ☐ Past ☐ _____

Family Health History

☐ Cancer ☐ High Blood Pressure ☐ Heart Problems ☐ Stroke ☐ Diabetes ☐ Other _____

Health History (C) Current (P) Past

c ☐ p ☐ Surgery/Hospitalization	c ☐ p ☐ Whiplash	c ☐ p ☐ High blood pressure
c ☐ p ☐ Serious injury/traumas	c ☐ p ☐ Diabetes	c ☐ p ☐ Chronic cough
c ☐ p ☐ Allergies	c ☐ p ☐ Bruise easily	c ☐ p ☐ Breathing difficulty
c ☐ p ☐ Migraines headache	c ☐ p ☐ Seizures	c ☐ p ☐ Visual disturbances
c ☐ p ☐ Rash/hives	c ☐ p ☐ Stroke	c ☐ p ☐ Atortic aneurysm
c ☐ p ☐ Chronic pain	c ☐ p ☐ Heart conditions	c ☐ p ☐ Numbess/tingling
c ☐ p ☐ Allergies	c ☐ p ☐ Bruise easily	c ☐ p ☐ Breathing difficulty
c ☐ p ☐ Vascular issues	c ☐ p ☐ Loss of sensation	c ☐ p ☐ Sinus trouble
c ☐ p ☐ Weakness/exhaustion	c ☐ p ☐ Varicose veins	c ☐ p ☐ Change in bowel/bladder habits
c ☐ p ☐ Osteoporosis/osteopenia	c ☐ p ☐ Cancer/tumors	c ☐ p ☐ Scoliosis
c ☐ p ☐ Loss of appetite	c ☐ p ☐ Bruise easily	c ☐ p ☐ Feeling of discomfort
c ☐ p ☐ Fever	c ☐ p ☐ nervousness	c ☐ p ☐ Anxiety
c ☐ p ☐ Depression	c ☐ p ☐ Bursitis	c ☐ p ☐ Auto-immune disorder
c ☐ p ☐ Disc issues	c ☐ p ☐ Nerve pain	c ☐ p ☐ TMJ disorder
c ☐ p ☐ Insomnia	c ☐ p ☐ Infections	c ☐ p ☐ Menstrual pain
c ☐ p ☐ Metal/surgical implants	c ☐ p ☐ Osteoarthritis	c ☐ p ☐ Rheumatoid arthritis
c ☐ p ☐ Tendinosis	c ☐ p ☐ Pregnant	

Any other conditions, further detail on the above or anything else you would like your provider to know: