Erie Shores Chiropractic

Kevin M. Francis, D.C.

Health Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____

Social Security Number _____ Email: _____

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____
May we update them on your condition? □ Yes □ No

Have you seen a Chiropractor Before? □ Yes □ No Whom? _____

Please answer the following to the best of your knowledge:
Please list all prescription, non-prescription medications and other supplements you take and the associated condition:
_____
_____
_____

Please list any surgeries or hospitalizations you have had with the approximate month and year for each:
_____
_____
_____

Please list any allergies:
_____
_____

Family History, please list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual:
_____
_____
_____

Do you:

- Have osteopenia or osteoporosis? □ Yes □ No □ Don't Know
- Exercise? □ Yes □ No Hours per week: _____ What activity(s)? _____
- Drink alcoholic beverages? □ Yes □ No _____ drink(s) per day / week / month / year
- Use Tobacco? □ Yes □ No Are you dieting? □ Yes □ No

What do you like to do in your spare time? _____

Is there ***a chance*** that you may be pregnant or nursing? □ Yes □ No How many weeks? _____

113 Madison Street | Port Clinton, OH 43452 | Phone: 419.732.CARE(2273) | Fax: 419.734.ERIE(3743)
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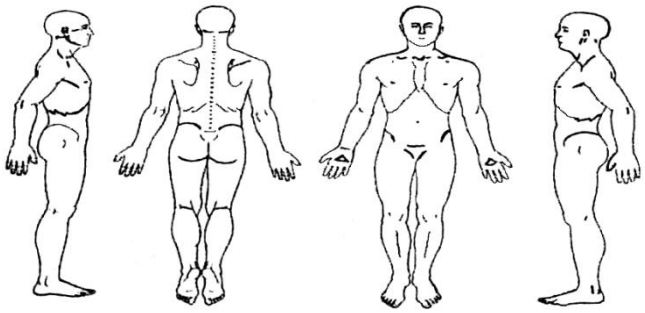
Symptom Questionnaire

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-Morning -Increase during the day

-Afternoon -Same all day

-Night -Decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
16. List any other major injuries you have had, other than those mentioned above:
    _____
17. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes
18. Whom may we thank for your referral? _____

I certify that the information provided is accurate to the best of my knowledge.

Patient or Parent/Guardian Signature _____ Date: _____

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INFORMED CONSENT

The following information is provided for your benefit and in order to inform you as to the practices, policies and procedures of Erie Shores Chiropractic (ESC).

As experts in the non-surgical care of spinal pain, we are distinguished healthcare providers that offer evidence-based management for your condition. What this means is that we utilize research-based guidelines and combine them with our clinical expertise in order to give you the best care possible and make you an informed patient. It is our philosophy that the best cares requires an educated patient and therefore, the following information has been provided.

Doctors of chiropractic, medical doctors, and physical therapists who use manual therapy techniques such as spinal adjustments (manipulation) are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

a) We use low-force manual manipulation techniques and gentle instrument-assisted techniques on those with a diagnosis of osteoporosis. While rare, some patients at other clinics have experienced rib fractures or muscle/ligament strains/sprains following spinal manipulation. These side effects may have been due to the use of excessive force and/or underlying osteoporosis.

b) Some believe that stroke is a rare side-effect of neck manipulation. The best available scientific evidence pertaining to this concludes that this is a highly unlikely association. Manipulation does not cause stroke; rather patients have reported to chiropractors and medical doctors with headache and/or neck pain (which can be initial symptoms of stroke), received treatment that failed to correctly diagnose their symptoms as a stroke, and then proceeded to have a stroke. This is why ESC stresses the importance of a thorough examination, and highlights our diagnosis-based treatment approach.

c) The most current evidence from the scientific literature indicates that spinal manipulation decreases pressure within the disc following treatment. However, there have been rare anecdotal cases reported of disc injuries following cervical or lumbar spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal manipulation.

Chiropractic treatments, including spinal manipulation, have been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches, and other symptoms due to painful spinal joints. Keeping in mind the diagnosis-based treatment concept, spinal manipulation is only one technique that is used in order to treat a diagnosis involving a painful spinal joint. At ESC, we utilize a myriad of treatment modalities to treat a narrow range of diagnoses for a wide range of patient types.

***** ***Please see reverse side of this form*** *****

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PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications of treatment I wish to rely on the doctor's expertise in clinical decision making during the course of my treatment based upon the facts then known. I understand that the results, while typical, are not guaranteed.

I acknowledge I have discussed or have had the opportunity to discuss with my chiropractor, the nature and purpose of the treatment as well as the contents of this consent.

I consent to the treatments offered or recommended to me by my doctor.

Print Name: _____

Signature: _____ **Date:_____**

HIPAA Acknowledgement

_____ (Initial) I have read a copy of the office HIPAA policies and have no further questions regarding the practices at Erie Shores Chiropractic.

Consent for Treatment

Assignment and Release-

By signing below, I authorize Erie Shores Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Erie Shores Chiropractic and I agree that a reproduced copy of this authorization will be valid as the original. I understand that I am responsible to know my insurance coverage, that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signature_____ Date:_____

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