



OPTIMUM
CHIROPRACTIC

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www.optimumchirowny.com

Reason for visit: _____

When did your symptoms start? _____

What were you doing when this happened? _____

Does anything seem to make it better or worse? _____

Is this condition (circle):

Getting better, fluctuates, about the same, getting worse, or not sure?

Type of pain (circle):

Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

Show where it hurts on the diagram on the right → → →

My pain when at its worse is (circle):

No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My pain right now is (circle):

No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My average pain level is (circle):

No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Activities or movements that are painful to perform (circle)

Sitting? Standing? Bending? Walking? Lifting?

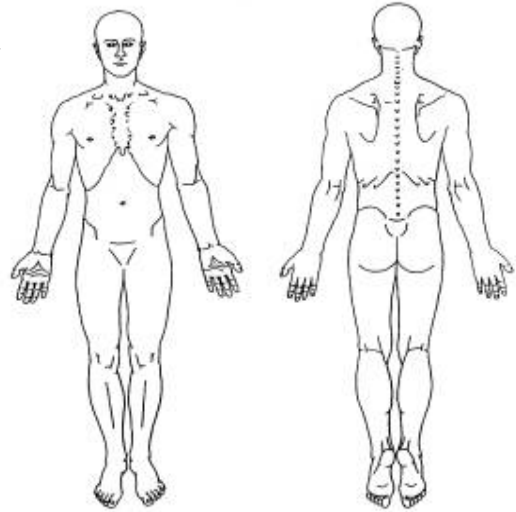
Turning? Driving? Reading? Lying Down?

Picking up objects? Working? Exercise/Sports?

Does it interfere with your (circle)

Work? Sleep? Daily Routine? Recreation? Other?

When / how often do you have this pain?



Are you seeking care due to an accident you were involved in? Yes No (if no, skip this section)

Date, time and location of accident: _____

Type of accident: Motor Vehicle Workplace Fall Other

Who did you report the injury to? _____

Were you evaluated at a hospital or by another health care provider for your injuries? Yes No

List any diagnoses from this encounter: _____

What treatments/surgeries/prescriptions were provided, if any?

Have you lost any days of work due to this accident? Yes No Dates: _____

Insurance Company Involved (No Fault, Worker's Compensation Carrier, etc)

Firm: _____ Name: _____ Phone: _____

Do you have an Attorney representing you in this case?

Firm: _____ Name: _____ Phone: _____

Patient Signature: _____

Date: _____ / _____ / _____

Modified George's Cerebrovascular Craniocervical Function History:

Have you ever been diagnosed with or treated for any of the following?

1. High Blood Pressure (hypertension) Yes No
2. Hardening of the arteries (arteriosclerosis) Yes No
3. Diabetes Yes No
4. Heart or blood vessel diseases Yes No
5. Bone spurs on the neck bones (cervical spondylosis) Yes No
6. Whiplash injury (flexion-extension injury of the cervical spine) Yes No
7. Have you or any of your immediate relatives ever suffered a stroke or mini-stroke (CVA or TIA)? Yes No
8. Were you ever a smoker? Yes No
If yes, from _____ to _____
9. Do you take blood-thinning or anti-platelet medications? Yes No
If so, which? _____
10. (Women Only) Have you ever taken oral Contraceptives? Yes No
If yes, from _____ to _____

Have you ever had any of the following, even as short or temporary attacks?

1. Dizziness, unsteadiness, giddiness, or vertigo? Yes No
2. Drop attacks, loss of consciousness, even momentary blackouts or sudden collapse without loss of consciousness? Yes No
3. Diplopia - Blurred or Double Vision? Yes No
Partial or complete loss of vision in one or both eyes?
4. Dysarthria- Slurred speech or other speech problems/difficulties? Yes No
5. Dysphagia - Difficulty swallowing? Yes No
6. Ataxia of gait - Difficulty walking due to lack of coordination of extremities, falling to one side, or any of the following: weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? Yes No
7. Nausea – Associated with movement or other symptoms listed here? Yes No
8. Numbness on one side of the face and/or body? Yes No
9. Nystagmus – abnormal involuntary eye movements? Yes No
10. Altered mental status including lack of understanding? Yes No
11. Hearing loss, ringing, buzzing or any noise in one or both ears? Yes No
12. Sudden severe pain in the side of the head and/or neck which is different from any other pain you have ever had? Yes No

Patient Signature: _____

Date: _____ / _____ / _____

Informed Consent Release:

Chiropractic as well as other types of health care is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform you of risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about potential risks related to your care to allow you to be fully informed in consenting to treatment.

Specific Risk Possibilities associated with Chiropractic care include:

1. Chiropractic adjustments are sometimes accompanied with **soreness**, with manipulation or later (post treatment soreness). Many things that can be done to minimize it. Specifically, we will instruct you with what you can do after treatment. Some post treatment soreness is common, not usually lasting more than 24 hours. Occasionally, Chiropractic treatment may aggravate or cause minor joint, ligament, tendon, disc or other soft tissue injury. Heat therapies can cause **burns**. Cryotherapy (Ice) can cause **frostbite**. Interferential and Ultrasound can cause minor burns. Soft tissue work can cause **bruising** and discomfort. While all of these side effects are uncommon, they should be reported to us immediately as well as any other side effects you may be experiencing.
2. In rare cases, manual adjustments may **fracture** a bone such as rib injury or fracture from thoracic spine adjustment. Precautions such as pre-adjustment x-rays may be taken on patients when we suspect someone is at risk. Treatment is performed carefully to minimize such risk.
3. **Stroke** is the most serious complication of Chiropractic Treatment but it is very rare. According to the Journal of CCA, VOL. 37, NO.2, @ 1993, Studies estimate the risk of stroke to be 1 in every 3 million upper cervical adjustments. Vertebral arteries which supply the brain with blood are located within the bones of the cervical spine, therefore cervical manipulation may pose a very small risk for stroke, which may result in temporary, or permanent brain dysfunction, and in extremely rare occasions, death.

The following are part of our ongoing in-house risk management program:

1. You complete a comprehensive case history form, and we attempt to gather diagnostic testing and other medical records. We review all the available information in consultation and correlate it with your symptoms and past history to identify possible risks as part of your condition.
2. Communicate with your physician(s) whenever possible.
3. We render the most conservative and safest treatments before resorting to more aggressive forms of care, and then only as appropriate. When risk exceeds benefit, we do not render care in the interest of your safety, nor do we assume any unnecessary risks.

Alternatives to Chiropractic care include, but are not limited to:

1. Pain **medications** do not attempt to fix the problem causing pain and hold the risk of dependence and liver and kidney damage over time.
2. **Surgery** is very beneficial when indicated but is often over used, does not always succeed, and can result in chronic pain syndromes. More conservative treatments, like Chiropractic, should usually be attempted first.
3. **Physical Therapy** is an excellent choice for rehabilitation and prevention of a reoccurrence but its active care model may worsen acute or unhealed injuries.
4. The major risk with receiving **no treatment whatsoever** is having a more complicated or emergent case that requires treatment go unrecognized. No treatment also leads to longer healing times with a higher likelihood of an incomplete recovery.

Chiropractic is a system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease. An attempt to provide the best Chiropractic care is our goal. If we are not successful, we will refer you to another Healthcare provider.

Do you have any questions about this information?

Patient Signature: _____

Date: _____ / _____ / _____

Past Medical History: Check all boxes that apply

1. General Health:

- Recent weight change
- On-going fever/chills
- Unexplained sweats
- Reoccurring allergies
- Anemia
- Unusual bleeding/bruising
- Malaise/fatigue/weakness
- Cancer
- Difficulty breathing with exertion
- Other _____

2. Skin/Hair/Nails:

- Change in skin color or texture
- Rashes/itching/lesions
- Skin growths
- Change in hair growth
- Change in shape of nails
- Change in condition of nails
- Other _____

3. Eyes/Ears/Nose/Throat:

- Visual problems
- Corrective lenses
- Redness/tearing/itching
- Pain in eyes
- Glaucoma
- Detached retina
- Difficulty hearing/deafness
- Ringing in ears/dizziness
- Ear pain
- Nosebleeds
- Changes in ability to smell
- Excessive sneezing
- Nasal growths/discharge
- Nose pain
- Sinus infection
- Change in voice/hoarseness
- Enlarged/painful glands
- Changes in ability to taste
- Other _____

4. Cardiovascular System:

- Heart attack
- Shortness of breath from exercise
- Chest discomfort/pain
- Palpitations
- Edema
- Fainting
- Calf pain when walking
- High blood pressure
- Past heart disease
- Other _____

5. Respiratory System:

- Difficulty breathing
- Abnormal cough
- Coughing up blood
- Asthma
- C.O.P.D./emphysema
- Tuberculosis
- Smoke/tobacco use
- Other _____

6. Gastrointestinal System:

- Changes in appetite
- Food allergy/intolerance
- Nausea/vomiting
- Vomiting blood
- Peptic/duodenal ulcer
- Indigestion/heart burn
- Abdominal pain
- Abnormal flatulence (gas)
- Changes in bowel habits/stool
- Diarrhea
- Hernia
- Hemorrhoids
- Gallbladder surgery
- Liver disease
- Pancreas disease
- Excessive alcohol use
- Other _____

7. Musculoskeletal System:

- Arthritis (Type: _____)
- Joint stiffness/pain
- Joint swelling
- Change in range of motion
- Joint dislocation
- Muscle cramps
- Muscle weakness
- Muscle wasting
- Muscle pain
- Strain/sprain
- Fractured bone
- Other _____

8. Neurological System:

- Headaches
- Seizures
- Dizziness/fainting
- Sensory disturbances
- Localized weakness
- Stroke/CVA/TIA
- Vertebral disc herniation
- Brain/spinal cord injury
- Other _____

9. Endocrine System:

- Heat/cold intolerance
- Thyroid problems
- Diabetes
- Other _____

10. Renal/Urinary System:

- Frequent urination
- Increased thirst
- Urinary urgency/pain
- Unusual urine color or smell
- Blood in urine
- Difficulty holding urine
- Difficulty passing urine
- Urethral discharge
- Flank/side pain
- Urinary tract infection
- Kidney disease/stone
- Dialysis
- Other _____

Patient Signature: _____

Date: _____ / _____ / _____

Past Medical History (continued) : Check all boxes that apply

11. Psychological:

- Anxiety
- Depression
- Bipolar
- Schizophrenia
- Post Traumatic Stress
- Anorexia/bulimia
- Other _____

12. Breasts (Male & Female):

- Breast lumps/masses/growths/pain/tenderness
- Dimples in breast
- Changes in color/shape/size
- Nipple discharge/bleeding
- Breast implants
- Other _____

13. Reproductive System:

- Unusual/missed periods
- Genital lesions
- Genital mass/growth/pain
- Sexually transmitted disease
- H.I.V./A.I.D.S.
- Other _____

List all medications, herbal supplements, vitamins and minerals you take and their doses:

List all surgeries, dates and reasons:

List all hospitalizations, dates and reasons:

Authorization and Acknowledgement

I have received a copy of my **Informed Consent Release**. I have read this authorization and I understand that it explains: (1) the risks and benefits of chiropractic care, (2) the risks and benefits of alternative treatments and (3) risks and benefits of not receiving or undergoing any treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to chiropractic care.

I have received a copy of the **Protected Health Information** policy. I have read this authorization and I understand that it explains circumstances in which I permit my health information to be used and shared with others. I authorize the uses and disclosures described in this authorization.

I have received a copy of the **Financial Policy**. I have read this policy and understand that it explains my responsibilities as a client of Optimum Chiropractic and agree to abide by the Financial Policy.

I understand all portions of this questionnaire and all answers are true and accurate to the best of my knowledge. My initials elsewhere in this document are equivalent to signatures.

Patient Signature: _____ Date: _____ / _____ / _____

Doctor Signature: _____ Date: _____ / _____ / _____