Kwan Yin Healing Arts Center East 3115 NE Sandy Blvd Suite 231, Portland, OR 97232 p: 503.701.8766 f: 888.972.5173

CHIROPRACTIC INFORMED CONSENT TO TREAT

I understand that a Chiropractic evaluation and treatment may include, but is not limited to: history intake, physical examination, spinal/extremity adjustments, massage and manual soft tissue therapy, instrument assisted soft tissue mobilization, therapeutic exercise training and prescription, nutritional and lifestyle advice.

Chiropractic examination and therapeutic procedures (including spinal/extremity adjustments, ultrasound, heat application, electrotherapy, manual muscle therapy and prescribed exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any 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. These complications include: stroke, neurologic impairment, injuries to the spinal discs, and spinal fractures. 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 Kara Giaier, D.C. and Jessica Budjac, D.C. 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 and will 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 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 performance of chiropractic treatment and other procedures within the scope of the practice of chiropractic. I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of 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

Patient signature Printed name Date

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PATIENT REGISTRATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Primary Telephone: _____ Email Address: _____

Date of Birth: _____ Gender: _____ Employment: _____ Hours/week: _____

Relationship Status: Single Married Partnered Separated Divorced Widowed Other

Live with: Spouse Partner Parents Children Friends Alone Roommates

How did you hear about our clinic?_____

Emergency Contact: Name_____ Relationship _____

Are you currently under the care of a medical professional? Y N

If yes, whom and where from?_____

If no, when and where did you last receive medical or health care and for what reason?

_____

Have you ever received chiropractic care? _____ Have you ever received massage therapy? _____

Do you have Health Insurance? Y N Insurance Provider: _____

Are your symptoms the result of an auto or work accident? Y N
(if yes, please notify front desk)

PRIMARY COMPLAINT

If you are here for wellness, please check here ☐ and continue to "Lifestyle"

Reason(s) for consulting this office: _____

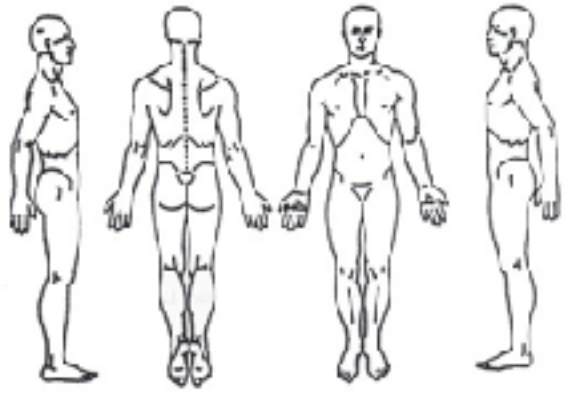
Date problem began: _____ Does it seem to be getting: Better Worse Staying the same

It interferes with: Sitting Work Sleep Walking Hobbies Leisure Other

Symptom Frequency (check those that apply):

- ☐ Constant (75% - 100% of the time)
- ☐ Frequency (51% - 75% of the time)
- ☐ Intermittent (26% - 50% of the time)
- ☐ Occasional (0% - 25% of the time)

Mark current problem areas on these pictures:



Please circle the level of discomfort your problem causes you when at its worst:

none 1 2 3 4 5 6 7 8 9 10 worst ever

When are symptoms the worst (check those that apply):

- ☐ Worse in the morning
- ☐ Worse in the afternoon
- ☐ Worse in the evening
- ☐ Symptoms don't change

Have you experienced this before? When? How frequently? _____

_____

What decreases symptoms (circle those that apply):

Ice Heat Medication Stretching Nothing helps Other:

Please describe any other complaints, if preset: _____

_____

What are the goals of your sessions/treatments: _____

_____

LIFESTYLE

	YES	NOTES
Do/did you smoke/use any tobacco?	☐	
Do/did you drink alcohol?	☐	
Do/did you use drugs?	☐	
Do you exercise?	☐	
Do you consider yourself to hold much stress?	☐	
Do you consume caffeine?	☐	
Do you drink a lot of water?	☐	

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FAMILY HEALTH HISTORY

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

HEALTH HISTORY

*Please circle all current conditions, underline all **previous** conditions*

Surgery/Hospitalization *(list below)*
Serious injuries/traumas *(list below)*
Allergies
Migraine headache
Rash or hives
Open wounds
Numbness/tingling
Loss of sensation
Weakness
Exhaustion
Vague feeling of discomfort
Unexplained weight loss/gain
Loss of appetite
Fever
Nervousness
Anxiety
Depression
Bursitis

Whiplash
Diabetes
Bruise easily
Seizures
Stroke
Chronic pain
Heart condition
Vascular issues
Varicose veins
Scoliosis
Auto-immune disorder
Disc issues
Insomnia
Nerve pain
TMJ disorder
Infections

Dizziness/fainting
Chronic cough
Breathing difficulty
Visual disturbances
Aortic aneurysm
High blood pressure
Osteoporosis/osteopenia
Cancer/tumor
Sinus trouble
Change in bowel/bladder habits
Menstrual pain
Metal/surgical implants
Osteoarthritis
Rheumatoid arthritis
Tendonitis
Currently pregnant
(Due Date: _____)

Space for conditions not listed above or further detail:

Please list all current and past long-term medications: _____

_____

_____

Any other information you'd like to share with the doctor: _____

_____

_____

All questions contained in this intake are strictly confidential and will become part of your medical record.

Printed Name of Patient	Signature of Patient	Date

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

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