Dr. Andrew Cherry & Associates

WELCOME

PLEASE PRINT

First Name:___________________________________**M.I.**_____ **Last Name:**____

Address:____**City:**________________________**State:**______**Zip:**__________

Birthdate:______/______/______ **Age**_______ **Gender:** □ Male □ Female □ Unspecified **SSN:**_________/______/________ **Primary Phone:**________________________ **Cell Phone:**___________________________ **Work Phone:**_________________________ **Home Email:**____ **Work Email:**____

Occupation:___________________________________**Employer:**____

Emergency Contact: (Name, Relationship, Phone #)____

Family Physician Name:____City:____

How were you referred to Dr. Andrew Cherry?

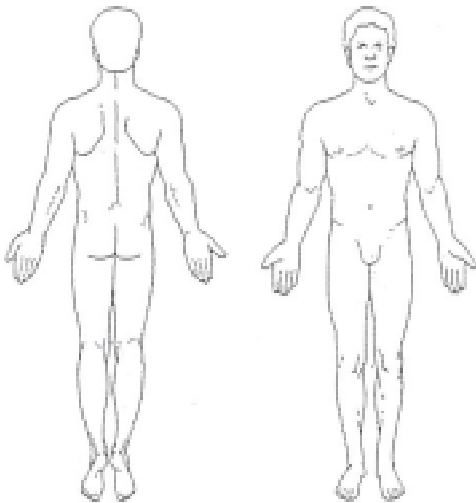
____

What is the reason for your visit today/what are your complaints?____

What caused this complaint(s)?____

When did this complaint begin? ______/______/______ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes **Have you had this or similar complaint in the past?** □ Yes □ No If "Yes", when?____

What does your complaint (s) feel like? Circle all that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*____________________________________



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

On the scale below, please circle the severity of your main complaint right now: 10 is severe

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

What area(s) does the pain radiate, shoot, or travel to? (if applicable)? ____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Acupuncture / Nothing / Other:_____________________

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information: Doctor's name:______________________________ Date consulted:___________________Diagnosis__________________________

Is this condition interfering with your: Circle all that apply Sleep / Getting in or out of bed or chair / Personal care / Travel / Work /

Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:__________________

WOMEN ONLY: **Currently Pregnant?** □ Yes □No

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

____

____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

____

____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No **List current prescription medications**, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week? Intensity?** □ Light □ Moderate □ Strenuous **Type?**
Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker **If "Yes"**, how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓: If "Yes"**, what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**
Do you drink alcohol? □ Yes □ No**How many drinks per week? For how many years?**
Do you drink caffeine? □ Yes □ No **How many drinks per day? What type?**□ Coffee □ Tea □ Soft Drinks □ Energy Drinks
Do you take pain killers? □ Yes □ No **How often?** □ Daily □ Weekly □ Monthly □ Rarely **What type?** □ Aspirin □ Ibuprofen □ Tylenol □ Other____________________________
What do your work duties include? □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other:
Please describe your overall health right now? □ Excellent □ Very Good □ Good □Fair □ Poor
What is your current stress level? □ Mild □ Moderate □ High
Have you seen a chiropractor in the past? □ Yes □ No
What are your hobbies?

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click",

much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

☐spinal manipulative therapy ☐palpation ☐vital signs ☐range of motion testing ☐orthopedic testing ☐basic neurological testing ☐muscle strength testing ☐postural analysis ☐EMS ☐ultrasound ☐hot/cold therapy ☐radiographic studies

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. **I have read** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor Andrew Cherry & Associates and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Doctor Andrew Cherry & Associates responsible for any errors or omissions that I may have made in the completion of this form nor will I hold Dr Cherry responsible for any damages or injuries from treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient’s Name (Please print) ____________________________________

Signature of Patient, Parent or Legal Guardian (if a minor) ____

Date: ____

By signing above, I acknowledge that I understand that I am financially responsible for all services at the time they are rendered.