



# Spinal Institute of Health

Get Checked. Get Well.

**NAME:** (First, M, Last) \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nick Name:** \_\_\_\_\_ **Gender:** M or F

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Social Security #:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Employer:** \_\_\_\_\_

**Employer Phone #:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Personal Phone #:** \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Cellular carrier:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ opt in for appt. reminders **email text msg.**

**Face book:** Y or N **Twitter** Y or N Y / N Y / N

**Spouse Name:** \_\_\_\_\_ **Spouses Phone:** \_\_\_\_\_

**Spouse Birthday:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spouses Occupation:** \_\_\_\_\_ **Spouses S.S.#:** \_\_\_\_\_

**Number of Children:** \_\_\_\_\_

**How did you hear about our office:** (please circle)

**Referral:** Who \_\_\_\_\_

Out of office talk    In office talk    Spinal Screening    Expo    Outside sign    Internet

Newspaper \_\_\_\_\_    Corporate Wellness    Other: \_\_\_\_\_

Is your condition due to an accident?    Work    Auto    Other: \_\_\_\_\_

**In case of emergency contact:** (name of relative or friend not living in your home)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

# Confidential Patient Case History

*Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.*

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – OCCASIONAL**  
**F – FREQUENT (weekly)**  
**C – CONSTANT (daily)**

**O F C**

**GENERAL**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

**MUSCLE & JOINT**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

**O F C**

**GASTRO-INTESTINAL**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE & THROAT**

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

**O F C**

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**RESPIRATORY**

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**SKIN**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**GENITO-UNRINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

**FOR WOMEN ONLY**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITION YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

**PLEASE PRINT**

What's your major complaint? \_\_\_\_\_

List surgical operation and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  
 "Pep" pills  Tranquilizers  Birth control pills

Others: \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heal lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident:  Past year  Past five years  Over five years  Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders?  Yes  No When? \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When? \_\_\_\_\_

**HAVE YOU EVER:**

Yes No

**DESCRIBE BRIEFLY**

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| Been knocked unconscious?                         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used a cane, crutch, or other support?            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been treated for a spine or nerve disorder?       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had a fractured bone?                             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized for anything other than surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**DO YOU:**

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| Now take vitamins or minerals?           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have an allergy to any drug?             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**DATE OF LAST:**

Less than 6 months

6-18 months

Over 18 months

Never

- |                      |                          |                          |                          |                          |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Spinal examination   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest X- ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**HABITS**

- |          |                          |                          |                          |                          |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
|          | Heavy                    | Moderate                 | Light                    | None                     |
| Alcohol  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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*Please initial near each statement to confirm your acceptance. Highlighted document names are in the Blue folder.*

\_\_\_\_\_ I have read and fully understand the **Terms of Acceptance** and therefore accept chiropractic care on this basis.

\_\_\_\_\_ I have read and fully understand the **Financial Office Policies** numbers 1-15 and agree to abide by these terms.

\_\_\_\_\_ I have read and fully understand the **Patient Consent for Use & Disclosure of Protected Health Information (HIPPA)**.

\_\_\_\_\_ Authorization to pay Doctor/Clinic is granted to Spinal Institute of Health, LLC.

\_\_\_\_\_ I authorize the Spinal Institute of Health to verify any and all insurance eligibility, benefits, claims status, or other pertinent insurance information. I also give permission to submit any and all charges to my insurance carrier/s with this one-time authorization.

\_\_\_\_\_ I authorize Dr. Benson to perform any radiographic examination necessary to diagnose and administer any treatment that is deemed necessary to treat my present condition or illness.

\_\_\_\_\_ To the best of my knowledge, I am Not Pregnant and Dr. Benson has my permission to x-ray me for diagnostic interpretation.

\_\_\_\_\_ I authorize Dr. Benson to update my family physician on my care here at the Spinal Institute of Health, LLC.

My Family Physician name & clinic \_\_\_\_\_

My Family Physician's/clinic phone# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
*Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_  
*Office Staff Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



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## Informed Consent to Chiropractic Treatment

**The Nature of Chiropractic Treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” similar to the noise produced when a knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

**Possible Risks:** As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone muscular strain, ligamentous sprain, dislocations of joints or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke; rather, recent studies indicated that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in associations with upper cervical adjustment is extremely remote.

**Probability of Risks Occurring:** The risks of complications due to chiropractic treatment have been described as “rare” to “extremely rare”, statistically less often than complications from taking a single aspirin tablet. There has not been a single reported injury in our clinic since its inception in 2009.

**Other Treatment Options** which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual Risks:** I have had the following unusual risks of my case explained to me.

**I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_ Date