

# Welcome to Palm Springs Chiropractic

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Female  Male Birthdate \_\_\_\_\_

Preferred Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Married  Widowed  Single  Divorced  Partnered for \_\_\_\_\_ Years

Patient Employed/School \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

## Symptoms

Reason for visit? \_\_\_\_\_ Symptoms started? \_\_\_\_\_

Where specifically is the problem(s) located? \_\_\_\_\_

Is the condition getting progressively worse, better, same? \_\_\_\_\_

Is the pain constant or intermittent? \_\_\_\_\_

### Type of pain

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

Rate the severity of your pain: (1=mild pain/discomfort, to 10=severe pain)

1 2 3 4 5 6 7 8 9 10

What treatment have you already received for your condition?

- Medication       Surgery       Physical Therapy       Other

Name and location of any other doctor(s) who have treated you for this condition:

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## Healthy History

Check only the conditions that are applicable

- |   |  |  |
|---|--|--|
| <input type="radio"/> Aids/HIV            | <input type="radio"/> Epilepsy           | <input type="radio"/> Pacemaker            |
| <input type="radio"/> Alcoholism          | <input type="radio"/> Fractures          | <input type="radio"/> Parkinson's Disease  |
| <input type="radio"/> Allergy Shots       | <input type="radio"/> Glaucoma           | <input type="radio"/> Pinched Nerve        |
| <input type="radio"/> Anemia              | <input type="radio"/> Goiter             | <input type="radio"/> Pneumonia            |
| <input type="radio"/> Anorexia            | <input type="radio"/> Gout               | <input type="radio"/> Polio                |
| <input type="radio"/> Arthritis           | <input type="radio"/> Heart Disease      | <input type="radio"/> Prostate Problem     |
| <input type="radio"/> Bleeding Disorder   | <input type="radio"/> Hepatitis          | <input type="radio"/> Prosthesis           |
| <input type="radio"/> Breast Lump         | <input type="radio"/> Hernia             | <input type="radio"/> Psychiatric Care     |
| <input type="radio"/> Bronchitis          | <input type="radio"/> Herniated Disc     | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Bulimia             | <input type="radio"/> High Cholesterol   | <input type="radio"/> STDs                 |
| <input type="radio"/> Cancer              | <input type="radio"/> Kidney Disease     | <input type="radio"/> Stroke               |
| <input type="radio"/> Cataracts           | <input type="radio"/> Liver Disease      | <input type="radio"/> Suicide Attempt      |
| <input type="radio"/> Chemical Dependency | <input type="radio"/> Measles            | <input type="radio"/> Thyroid Problems     |
| <input type="radio"/> Chicken Pox         | <input type="radio"/> Miscarriage        | <input type="radio"/> Tonsillitis          |
| <input type="radio"/> Diabetes            | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Tuberculosis         |
| <input type="radio"/> Emphysema           | <input type="radio"/> Osteoporosis       | <input type="radio"/> Tumor/Growths        |

Is there anything else you want us to know?

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### Chiropractic informed consent to treat


I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays and supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic care indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure where what the doctor feels at the time based upon the facts then known is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxers and painkillers, physical therapy, steroid injections, bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Palm Springs Chiropractic, Dr. Scott Redfern 

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or Patient Guardian/ Parent/ Representative) (provide name and relationship if signing for patient)