Informed Consent Document

Patient Name:_____

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 used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That 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 a part of the analysis, examination, and treatment, you are consenting to the following procedures, please initial each procedure you are consenting to:

____spinal manipulative therapy____palpation____vital signs
____range of motion testing____orthopedic testing____basic neurological testing
____muscle strength testing____postural analysis testing
____ultrasound____hot/cold therapy____EMS (electrical muscle stimulation)
____radiographic studies
____other

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 treatment. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The Probability of Those Risks Occurring

Fractures are rare occurrences, and generally result from some underlying weakness of the bone which we check for when taking your history and during examination and X-ray. Stroke and/ or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on this topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The Availability and Nature of Other Treatment Options

--Other treatment options for your condition may include:
--Self administered, over-the-counter analgesics and rest
--Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
--Hospitalization
--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.

Consent To Treatment (Minor)

I hereby request and authorize *DocSide Chiropractic LLC.* to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (Colleen Dittmar D.C. or Kara Shannon D.C.) and have had my questions answered to my satisfaction. 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.

Dated: _____ Dated: _____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

1134 Front Street
Buffalo IA 52728

Phone 563-823-8836
Fax 563-823-8305

DocSide Chiropractic

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Patient Name_____
Last First MI
Address _____
City_____State_____Zip_____
Home Phone _____Cell Phone _____
Work Phone_____ext_____
E-Mail _____
Gender __Male ___Female SS# _____
Birthdate _____ Age ___ Race_____
__Married __Widowed __Divorced __Separated
__Single __Partnered for___ years __Minor
Patient Employer/School _____
Occupation _____
Employer/School Address
_____
Spouse's Name _____
Spouse's Birthdate_____ Age ___
Employer_____
Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Primary Insurance
Company_____
Subscribers Name _____Birthdate_____
Relationship to Patient_____
ID_____Group Number_____
Secondary Insurance
Company_____
Subscribers Name_____Birthdate_____
Relationship to Patient_____
ID_____Group Number_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with_____and assign directly to
Name of Insurance Company(ies)
Dr. Colleen Reed-Dittmar all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and agree to pay any co-payments at time of service. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.
I understand that In the event that my insurance company will not assign benefits directly to the provider that I will be responsible for the full price of the visit, payable to DocSide Chiropractic, LLC.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 EMERGENCY CONTACT INFORMATION

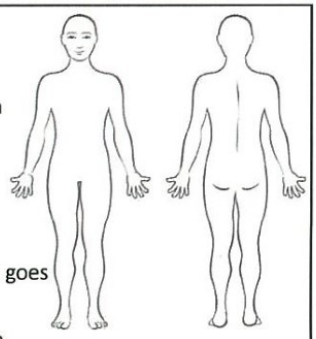
Name_____ Relationship_____
Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Yes __No
Type of accident __Auto __Work __Home __Other
To whom have you made a report of your accident?
__Auto Insurance __Employer __Worker Comp. __Other

5 PATIENT CONDITION

Reason for Visit_____
When did your symptoms begin?_____ Is it getting progressively worse? __Yes __No __Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting
__Burning __Tingling __Cramps __Stiffness __Swelling __Other
How often do you have this pain?_____ __The pain is constant __The pain comes and goes
Does it interfere with your __Work __Sleep __Daily Routine __Recreation
Activities or movements that are painful to perform __Sitting __Standing __Walking __Bending __Lying Down



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FAMILY HISTORY

Family history of Cancer, Disease, Stroke, Cardio, Etc...? Please list family member(s):

_____ _____

_____ _____

_____ _____

HEALTH HISTORY

What treatment have you already received for your *current* condition?

__Medication __Surgery __Physical Therapy __Chiropractic Services __None __Other_____

Name and address of other doctor(s) who have treated you for your *current* condition_____

_____

Date of Last X-Ray_____Area of X-Ray_____

Diet; __Mostly Natural/ Whole Food __Mostly Processed/ Packaged Food __ Combination of Both Water Intake; _____ Cup(s) per day

Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV __Yes __No	Diabetes __Yes __No	Liver Disease __Yes __No	Rheumatoid Arthritis __Yes __No
Alcoholism __Yes __No	Emphysema __Yes __No	Measles __Yes __No	Rheumatic Fever __Yes __No
Allergy Shots __Yes __No	Epilepsy __Yes __No	Migraine Headaches __Yes __No	Scarlet Fever __Yes __No
Anemia __Yes __No	Fractures __Yes __No	Miscarriage __Yes __No	S.T.D. __Yes __No
Anorexia __Yes __No	Glaucoma __Yes __No	Mononucleosis __Yes __No	Stroke __Yes __No
Appendicitis __Yes __No	Goiter __Yes __No	Multiple Sclerosis __Yes __No	Suicide Attempt __Yes __No
Arthritis __Yes __No	Gonorrhea __Yes __No	Mumps __Yes __No	Thyroid Problem __Yes __No
Asthma __Yes __No	Gout __Yes __No	Osteoporosis __Yes __No	Tonsillitis __Yes __No
Bleeding Disorders __Yes __No	Heart Disease __Yes __No	Pacemaker __Yes __No	Tuberculosis __Yes __No
Breast Lump __Yes __No	Hepatitis __Yes __No	Parkinson's Disease __Yes __No	Tumors, Growths __Yes __No
Bronchitis __Yes __No	Hernia __Yes __No	Pinched Nerve __Yes __No	Typhoid Fever __Yes __No
Bulimia __Yes __No	Herniated Disk __Yes __No	Pneumonia __Yes __No	Ulcers __Yes __No
Cancer __Yes __No	Herpes __Yes __No	Polio __Yes __No	Vaginal Infections __Yes __No
Cataracts __Yes __No	High Blood Pressure __Yes __No	Prostate Problem __Yes __No	Whooping Cough __Yes __No
Chemical Dependency __Yes __No	High Cholesterol __Yes __No	Prosthesis __Yes __No	Other _____
Chicken Pox __Yes __No	Kidney Disease __Yes __No	Psychiatric Care __Yes __No	_____

EXERCISE
__None
__Moderate
__Daily
__Heavy

SMOKING STATUS (Circle one and fill in ages if applicable)

Never Smoker Former Smoker (Age started____ Age Quit____) Current Every Day Smoker (Age Started____)
Current Some Day Smoker (Age Started____)

ALCOHOL INTAKE (Circle One)

None Social Drinker Weekend Drinker Every Day Drinker

HOBBIES (Circle All That Apply)

Sports Gardening Fishing Crafts Dancing

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	START DATE	DOSAGE	FREQUENCY

ALLERGIES	REACTION