

Advanced Chiropractic Wellness Center

Dr. Scott Stratton

20500 S. LaGrange Road, Frankfort, IL 60423

Phone (815) 464-6772 Fax (815) 464-8051

Consent To Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by Scott Stratton, D.C., and / or other licensed doctors of chiropractic who may be employed by or engaged in practice at the Advanced Chiropractic Wellness Center.

I have had an opportunity to discuss with Scott Stratton, D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he / she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

Date

Patient Name

Patient Signature

Relationship or Authority
(if not signed by patient)

Doctor's Notes

Patient counseled by the use of the following:

_____ Discussion
_____ Other (Please Specify)

X _____
Signature of Doctor or Other

**ADVANCED CHIROPRACTIC WELLNESS CENTER
SCOTT STRATTON, D.C.**

Personal and Family Health History

Name _____ Date of Birth _____ (Age _____)
Date _____ Referred By _____
Address _____ Occupation _____
City _____ State _____ Zip _____ Employer _____
Phone: (H) _____ Marital Status S M D W
(W) _____ Spouse's Name _____
(C) _____ Spouse's Occupation _____
Email _____

Number of Children and Ages

Previous Chiropractic Care?

Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic / metabolic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today

Major _____

What caused this problem and when ? _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Current Health Condition Continued

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Surgeries? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Other symptoms:

- Headaches
- Migraines
- Insomnia
- Sleepy
- Chronic pain
- Diabetes
- Arrhythmia
- High blood pressure
- Colitis
- Itching
- Dizziness
- Allergies
- Seizures
- PMS
- Decreased urination
- Increased urination
- Fatigue
- Depression
- Anemia
- Auto Immune
- Rheumatoid Arthritis
- Arthritis
- Asthma
- Diarrhea
- Ulcers
- Constipation
- Vertigo
- Indigestion

**Chiropractor's
Comments**

Check all that Apply

1. Was Your Birth Traumatic?

Long Delivery ____ Difficult Delivery ____ Forceps ____ Caesarian ____ Breach/cephalic ____

Home birth ____ Mother given drugs during delivery ____ Induced Labor ____

2. Current Health Habits

Smoke ____ Drink ____ Diet (do you eat healthy foods?) ____ Exercise regularly ____

Hobbies ____ artificial sweeteners ____ sleeping posture: side – stomach – back

3. Injury History

List physical injuries and when (auto, sports, falls, etc.) _____

List history of chemical stress _____

List history of emotional/mental stress (loss of loved ones) _____

4. Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a result of my chiropractic / metabolic care, I would like to:

Please check all that apply

- Feel better quickly
- Have a healthier spine
- Have a healthier body by keeping my biochemistry / metabolic system healthy
- Have a healthier body by keeping my nerve system healthy
- Live a healthier lifestyle

Please list all nutritional supplements that you take (ie minerals, vitamins, herbs, homeopathics, flower essences, remedies, etc.), and approximately how long you have taken them:

Please list all forms of exercise that you do currently (ie walking, weight training, yoga, aerobics, etc.), how long, and how often you exercise:

Signature _____

Date _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

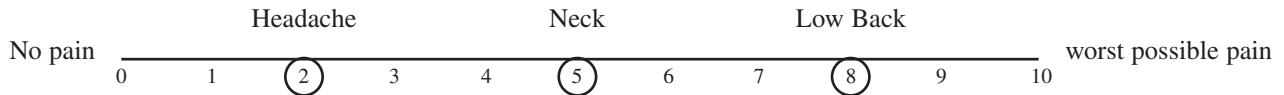
Date _____

Please read carefully:

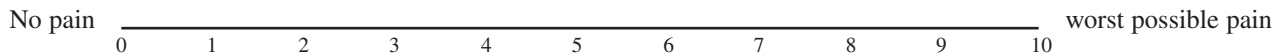
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

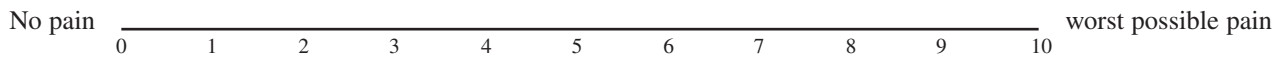
Example:



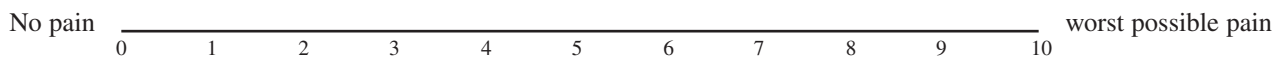
1 – What is your pain RIGHT NOW?



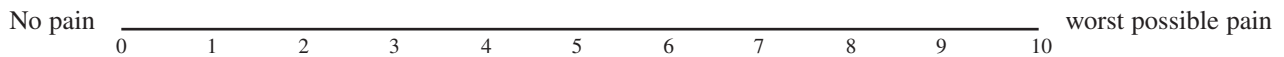
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain: 25% of the day	Intermittent pain: 50% of the day	Frequent pain: 75% of the day	Constant pain: 100% of the day

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain: no restrictions	Mild pain: no restrictions	Moderate pain: need to go slowly	Moderate pain: need some assistance	Severe Pain: need 100% assistance

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

9. Walking

0	1	2	3	4
No pain: any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work: no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____

PRINTED

ID# _____

Plan ID _____

Total Score _____

Revised 10/97

Signature _____

Date _____