# ON THE GO CHIRO

Dr. Tory Brooks, Chiropractic Physician 3250 N. Campbell Ave., Ste.132, Tucson, AZ 85719 **520.881.0650**

## Patient Registration and History Questionnaire

Name: _____ Age: _____ Date of Birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email: _____

Employer: _____ Occupation: _____

How did you find out about us? _____

**In case of emergency, notify** _____ **Relationship:** _____ **Phone (_____)**_____

**Chief Complaint or Reason for Office Visit:** _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms **better**? _____ What makes your symptoms **worse**? _____

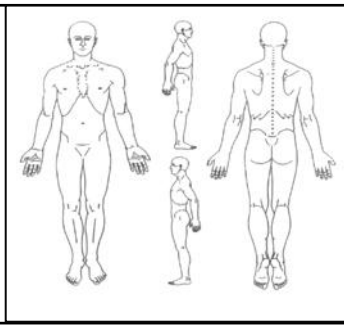
What is your pain **right now**? No pain _____ Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

**Please mark on the diagram to the right the following symbols as they relate to your symptoms:**

| | |
|---|---|
| SS = spasms | ST = stiffness |
| DP = dull pain | SP = sharp pain |
| SH = shooting pain | TI = tingling |
| NU = numbness | A = ache |
| BN = burning | TH = throbbing |



**Please list all medications and dosage:** **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, food or other: _____

**Are you pregnant? ☐ Yes ☐ No** First day of last menstrual cycle: _____

Do you smoke? ☐Yes ☐No; How much? _____ Do you drink alcohol? ☐Yes ☐No; How much?_____

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Patient's Name: _____ Date: _____

**Please list all serious illness and serious accidents:** **Month and Year** **City, State**

_____

_____

_____

**Please list any recent x-rays, lab or other tests:** **Date** **Facility/Doctor**

_____

_____

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tuberculosis | ☐ Yes | Lung Disease | ☐ Yes | Gout | ☐ Yes | Diabetes | ☐ Yes |
| Kidney Disease | ☐ Yes | Stomach/Ulcer | ☐ Yes | Heart Disease | ☐ Yes | Hepatitis | ☐ Yes |
| Sciatica | ☐ Yes | Blood Pressure | ☐ Yes | Transfusion | ☐ Yes | Polio / MS | ☐ Yes |
| Colon Disease | ☐ Yes | Stroke | ☐ Yes | Cancer | ☐ Yes | Bleeding | ☐ Yes |
| Paralysis | ☐ Yes | Seizures | ☐ Yes | Arthritis | ☐ Yes | Asthma | ☐ Yes |
| Anemia | ☐ Yes | Thyroid Disease | ☐ Yes | Drug Dependence | ☐ Yes | AIDS | ☐ Yes |

Any other condition(s) not listed above that the doctor should be made aware of:

_____

**HIPAA Compliance**

ON THE GO CHIRO is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness:_____ Date: _____

Staff Initials: _____

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## Informed Consent

**The nature of chiropractic manipulation:** I will use either my hands, an instrument or both to move the joints of your body; this may result in an audible "pop" or "click".

**The material risks inherent in an adjustment:** As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

**The probability of those risks:** Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

**Ancillary treatments recommended:** Ice, Moist Heat Packs, Cervical Traction and Non-Invasive Neurostimulation Treatment System.

**Risks involved with the recommended ancillary treatments:** Ice and Moist Heat Packs can cause burning. Cervical Traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

**Other treatment options for your condition can include:** Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor 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 I have decided that in was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

**Patient Printed Name**_____ **Date**_____

**Patient Signature**_____ **Dr.** _____

**The patient had the following questions and was supplied the following answers:**

_____

_____

**It is my clinical opinion this patient is oriented to time and space: Yes No**

**It is my clinical opinion this patient was able to understand the language involved: Yes No**