**CHIROPRACTIC QUESTIONAIRE**

**Shiloh Pain and Primary Care**

**First Name**: \_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

Reason for visit:

Is this injury due to a work or vehicle accident? Yes / No Is this the first episode of neck/back pain? Yes / No

How long have you experienced neck/back pain? When did you first notice the symptoms?

What activities are difficult to perform?

□ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Other

Describe your type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Other

Rate the severity of your pain: [**1 = mild - 10 = worst possible**] (circle one) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? □ Constant □ Comes and goes

Other doctors that you have seen for this condition:

Diagnosis: Treatment received:

X-rays taken? Yes / No Other tests performed? Yes / No

If yes, list test, where taken and results:

**Health History** (Check only those conditions which apply to you)

□ Allergies □ Cardiac Arrhythmia □ Epilepsy □ High Blood Pressure □ Neck Pain

□ Ankle Pain □ Constipation □ Female Disorders □ Hip Pain □ Osteoporosis

□ Arthritis □ Chronic Bronchitis □ Fractures □ Indigestion □ Shoulder Pain

□ Asthma □ Depression □ Headaches □ Irritable Bowel □ Stroke

□ Back Pain □ Diabetes □ Heart Disease □ Kidney Disease □ Ulcer

□ Blood Clots □ Elbow Pain □ Hernia □ Liver Disease □ Other

□ Cancer □ Emphysema □ Herniated Disc □ Migraine

(Women) Are you pregnant? Yes / No Taking birth control pills? Yes / No

Current Medications:

Previous Surgeries:

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Informed Consent**

I understand that all health care treatments carry the possibility of complications. A staff provider from Shiloh Pain & Primary Care has informed me of possible risks of chiropractic manipulation and related treatment, including stroke, and I understand the risks. A copy of *“Spinal Care Treatment Options: The Risks and Benefits”*is posted in the office and is available upon request.

I have discussed other treatment options and their associated risks and benefits with a staff provider, and all of my questions have been answered. A staff provider has recommended chiropractic manipulation and/or related treatment, and I choose to follow the staff provider’s recommendation.

I request and give my consent for chiropractic manipulation and/or related treatment. I intend for this consent to cover all treatments now and in the future by any staff provider of Shiloh Pain & Primary Care.

***I have read (or had read to me) the above consent.***

Print Name: Date:

Signature:

Parent/Guardian Name:

Provider Signature: Revised: 1/1/2019