Intake Form

mend

Patient Information

Patient Name _____ Date of Birth _____ Age _____

Cell Phone Number _____ Email _____ *Male* *Female*
(will be used to sign in)

Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone Number _____

How did you hear about our office? _____

Are you Medicare eligible? *Yes* *No*

Acceptance of Care

WHAT WE OFFER

At mend, we offer chiropractic adjustments, spinal decompression, massage therapy, other soft tissue techniques, and infrared sauna therapy. Our goal is to improve the overall function of the body, which may result in better mobility, reduced tension, and less pain.

In order to administer safe and effective treatments, our licensed providers will perform a comprehensive patient history and physical exam. This may include a spinal exam, which will assess the function and integrity of the spine, and will determine if any subluxations or dysfucntion are present.

When indicated, our licensed providers may feel it is necessary to perform additional tests such as diagnostic x-ray, MRI, or other physical procedures before beginning care. If additional testing is needed, our licensed providers will make referrals to the appropriate health care facility. This may mean you will not be seen on the date of your initial visit, or will not been seen at all, if it has been determined unsafe.

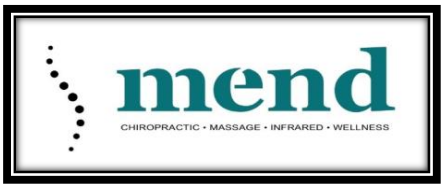
WHAT WE DO NOT OFFER

We do not offer to diagnose or treat any condition other than subluxations, or joint dysfunction, of the spine and extremities, and/or related nueromusculoskeletal conditions.

mend is a non-insurance office. This means we do not bill major medical, medicare, or automobile insurance for your care. We do not and will not use insurance codes for the treatments we render.

I, _____, have read and fully understand the above explanation of care. I accept and consent to the chiropractic care described above.

Patient or Guardian Signature _____ Date _____



Intake Form

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent”, and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations, as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological function and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravation of and/or temporary increase in symptoms, lack of improvement in symptoms, burns and/or scarring from electrical stimulation and/or hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that is typically caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that the chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare, and is estimated to be related to one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin-induced major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons per year, and risk of death has been estimated as 104 per one million users.

It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion, and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every potential complication to care. I have also had the opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition, and for any future condition(s) for which I seek chiropractic care from this office.

I acknowledge I have read and understand the statements above _____
initial

Intake Form

Informed Consent to Care Continued

You understand that the risks associated with soft tissue therapy include, but are not limited to:

Superficial bruising

Short-term muscle soreness

Exacerbation of an undiscovered injury

This office does NOT perform chest/breast massage on female clients.

Proper draping techniques will be used during the massage and stretch.

If you are uncomfortable for any reason during any treatment, you may ask to end the session, and it will end immediately.

You understand that massage and stretch therapy are not a substitute for traditional medical treatment, chiropractic care, or medications.

You have obtained clearance from your physician to receive massage and/or stretch therapy.

You understand the importance of informing the providers of ALL medical conditions and medications, and will update them if any changes occur.

You understand there may be additional risks not yet discussed based on your physical condition.

You understand that it is your responsibility to inform the providers of any discomfort experienced during the sessions so that the therapist can adjust accordingly.

Do not use drugs, tobacco, or alcohol prior to or during sauna sessions.

No one under the age of 18 is permitted in the sauna unless accompanied by a guardian.

Elderly patients should consult with their primary care physician prior to using the sauna.

I acknowledge and accept the inherent risks of infrared sauna therapy. I voluntarily assume the risk of injury, accident, or death which may arise from the use of infrared sauna therapy. I agree that this release is effective for all current and future infrared sauna sessions. None of the information provided regarding the benefits of infrared sauna use is intended to act as a substitute for medical advice, nor does it involve the diagnosis, treatment, or certain outcome for any disease or ailment.

You have been given a chance to ask any questions about any treatments in our office, and any questions have been answered.

I acknowledge I have read and understand the statements above _____
initial

Patient Name _____ Signature _____ Date _____

Parent or Guardian Name _____ Signature _____ Date _____

Witness Name _____ Signature _____ Date _____