PATIENT NAME (First) _____ (Last) _____ (M)____ DATE: _____

MAILING ADDRESS: _____CITY_____ STATE_____ ZIP_____

CELL PHONE: _____ WORK: _____ HOME: _____

DATE of BIRTH: _____/_____/_____ SOC. SEC.#: _____ EMAIL: _____

SEX: ___ Male ___ Female MARITAL STATUS: ___ Married ___ Single ___Divorced ___Widowed ___ Other

EMPLOYER/SCHOOL: _____OCCUPATION: _____

NAME of SPOUSE: _____ SPOUSE DOB: _____

SPOUSE'S PHONE: _____ EMPLOYER: _____

EMERGENCY CONTACT PERSON: _____ PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____ ADDRESS: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY:_____ ID# _____ GROUP# _____

SECONDARY: _____ ID# _____ GROUP#: _____

PRIMARY INS PHONE #:_____ SECONDARY INS PHONE #: _____

LIST ALL PRESCRIPTION MEDICATIONS YOU CURRENTLY USE:

Primary Complaint(s): _____

Cause of injury or symptoms: _____

Date of onset of symptoms: _____

Circle when your symptoms are worst: *Mornings* *Evenings* *Daytime* *Sleeping* *Constant* *Related to Activity*

Circle the severity of your symptoms: *Mild* *Moderate* *Intense* *Severe* *Worst Pain In My Life*

Do any of the following help: *Ice* *Heat* *Massage* *Rest* *Pain Medication* *Walking*

Are you experiencing any (circle): *Numbness* *Tingling* *Burning* *Weakness* *Bowel or Bladder Changes*

What aggravates your condition? _____

What other treatment have you received for this problem? _____

Is your condition getting progressively worse?	Yes	No	Have you had this same problem before?	Yes	No
Do you have a history of corticosteroid use?	Yes	No	Do you have a pacemaker or defibrillator?	Yes	No
Do you wear shoe inserts?	Yes	No	Women: Is there any chance you could be pregnant?	Yes	No
Are you allergic to any medications?	Yes	No	_____		

Please check if you have a history of any of the following:

__AIDS/HIV	__Cataracts	__Heart Disease	__Multiple Sclerosis	__Prostate Problems
__Alcoholism	__Chemical Dependency	__Hepatitis	__Mumps	__Seizures
__Allergy Shots	__Chicken Pox	__Hernia	__Osteoporosis	__Typhoid Fever
__Anemia	__Corticosteroid Use	__Herniated Disc	__Pacemaker	__Stroke
__Anorexia	__Gout	__Herpes	__Parkinson's Disease	__Ulcers
__Anxiety	__Gonorrhea	__High Blood Pressure	__Pinched Nerve	__Suicide Attempt
__Appendicitis	__Goiter	__High Cholesterol	__Pneumonia	__Vaginal Infections
__Arthritis	__Glaucoma	__Mononucleosis	__Polio	__Thyroid Problems
__Asthma	__Fractures	__Miscarriage	__Scarlet Fever	__Venereal Disease
__Bleeding Disorders	__Epilepsy	__Migraines	__Rheumatic Fever	__Tonsillitis
__Breast Lump	__Emphysema	__Measles	__Rheumatoid Arthritis	__Weight Loss
__Bronchitis	__Diabetes	__Liver Disease	__Joint Replacement	__Whooping Cough
__Bulimia	__Depression	__Kidney Disease	__Psychiatric Care	__Tuberculosis
__Cancer	__Hearing Loss	__Hypoglycemic	__Prosthesis	__Tumors, growths

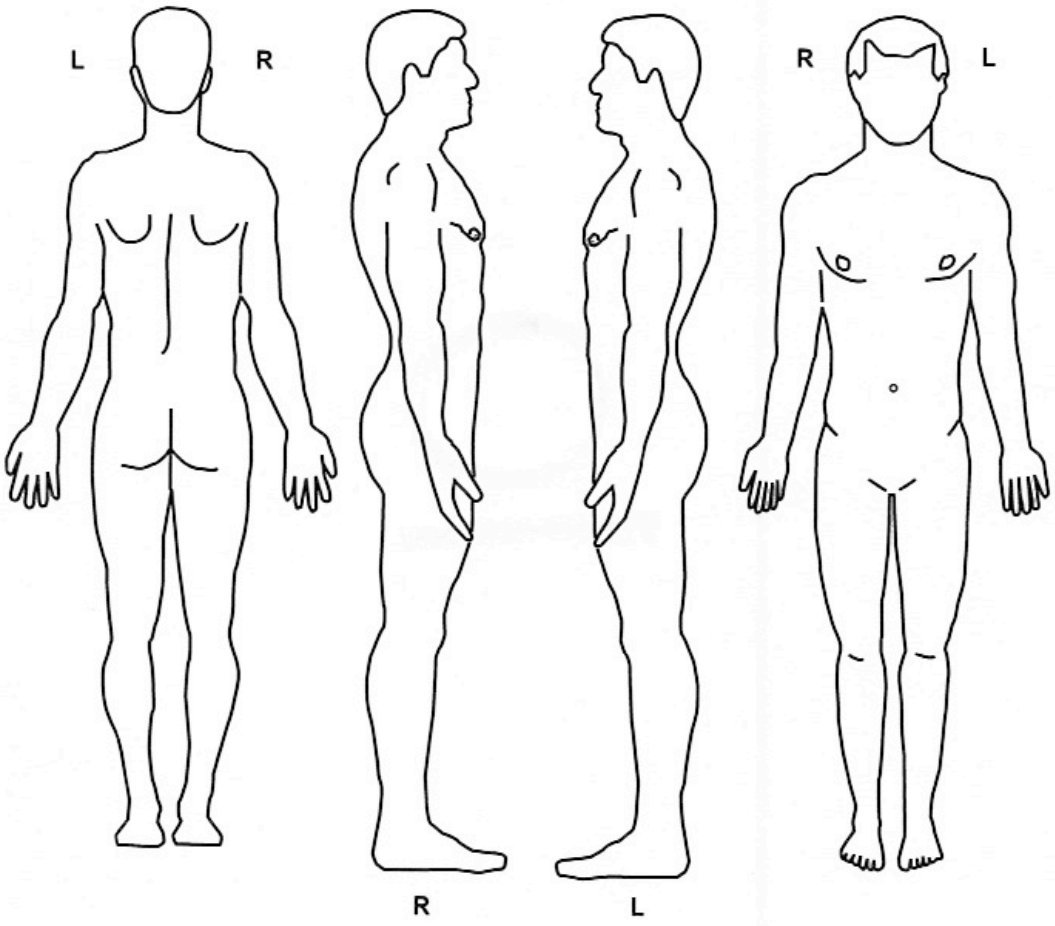
Please check if you have a family history of the following:

__Heart Disease	__Migraines	__Arthritis	__High Cholesterol	
__Cancer	__High Blood Pressure	__Depression	__Stroke	__Diabetes

OFFICE USE ONLY:

PAIN DRAWING

Name _____ Date _____



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

PATIENT ACKNOWLEDGMENT REGARDING
NOTICE OF PRIVACY PRACTICES
(HIPAA Privacy Document)

I have had the opportunity to review the Notice of Privacy Practices and, *if requested*, have been supplied with a copy of those practices.

Patient Name:_____ Date:_____
(Please Print)

_____
Signature of Patient, Parent, Guardian, or Personal Representative

****

The HIPAA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the individual's office, instead of the individual's home.

In the event that Dr. Rudkin's office may need to contact me, I give my consent to the following methods of communication:

1. Message on home or cell phone with detailed information.
2. Text Message on home or cell phone with detailed information.
3. Message on work telephone (if applicable) with detailed information.
4. Written Communication to my home or work.

_____ DOB: _____ Date: _____
Signature of Patient, Parent, Guardian, or Personal Representative

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.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Adjustments are performed with 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 functioning and overall well-being. Some diagnostic and/or examination procedures may be uncomfortable.

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, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, bone fractures, disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is 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 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 in 1/1,000,000 to 1/2,000,000 cervical adjustments. For comparison, the incidence of hospital admission for major GI events of the entire (upper and lower) GI tract, attributed to aspirin use, was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand 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 possible complication to care. I have also had an 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.

Print Patient Name: _____ Signature: _____ Date: _____

Guardian: _____ Signature: _____ Date: _____