

# Truckee Mobile Chiropractic

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Credit Card #(if applicable): \_\_\_\_\_ Exp: \_\_\_\_\_ CSV#: \_\_\_\_\_

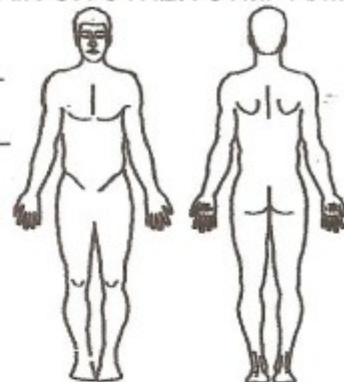
**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.**

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Height \_\_\_\_\_

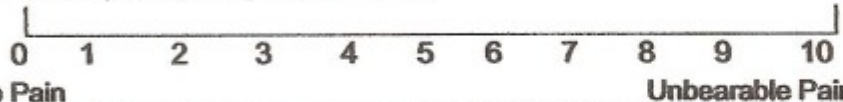
Weight \_\_\_\_\_



Is this?  Work Related  Auto Related  N/A

**DATE PROBLEM BEGAN:** \_\_\_\_\_

Current complaint (how you feel today):



How often are your symptoms present?  0 – 25%  26 – 50%  51 – 75%  76 – 100%  
 Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?**  No  Yes Date(s) taken: \_\_\_\_\_

**WHAT AREAS WERE TAKEN?**

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         | <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |                          |                          | _____   |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

In accordance with California law, this notice is to inform you, the patient, the risks of undergoing chiropractic care. The procedures that will be performed in the course of your care will consist of chiropractic adjustments using manual and instrumental techniques. The risk of care could include possible fracture of ribs (if you have unusually low bone density). This risk will be evaluated before your care begins. Another risk from a chiropractic adjustment is the risk of stroke. This risk has been determined to be a risk of approximately 1 in 5.85 million. This risk will also be evaluated prior to the onset of your care to see if you have any predisposing factors for a stroke. Furthermore, any medications the patient is taking may have a direct influence on his or her reaction to the adjustment. The medications the patient may be taking may have more adverse health affects and complications. There is also the risk of increased pain during the healing phase of care. As your body begin to be restored to normal health, there may be some periods of time when you will feel symptoms that had previously been gone. Understand that this is normal and indicates healing, as such you may also risk restored health and wellness. The risks of not getting chiropractic adjustment can include disc and spine degeneration, loss of mobility, loss of function of organs or cells that do not have nerve supply retored to them and loss of muscle tone.

My signature below signifies that the risks of chiropractic care have been explained to me verbally and in the above written statement. I understand the risks and give consent for chiropractic treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_