KOSTERMAN
CHIROPRACTIC

Patient Intake Information

First Name: _____

Last Name: _____

Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Date of Birth: ____-____-_____

Gender: ☐ Female ☐ Male ☐ Other

Name of Spouse: _____

Name of Children: _____

Emergency Contact Name: _____

Phone Number: _____

How did you hear about Kosterman Chiropractic?

Internet **Physician** **Word of Mouth** (Who_____)

Other_____

KOSTERMAN
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Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that is bothering you the most today?

_____

_____

_____

How did your symptoms begin? _____

_____

Pain level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better or Getting Worse

Is your condition: On & Off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Pain Radiating: Left/Right Base of skull Shoulder Arm Hand

Hip Leg Knee Foot Ribs Other: _____

What makes it better? Ice Heat Rest Movement Stretching

What makes it worse? Sitting Standing Walking Lying down Sleep

Overuse Other: _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Auto Fall Work

List of Medications you are taking:

_____

_____

List of past surgeries: _____

Do you have any other complaints? _____

_____

Patient Signature: _____

FOSTERMAN CHIROPRACTIC

Functional Rating Index

We must understand how much your symptoms have affected your ability to manage everyday activities. For each item please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50 % of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Internal Use Only 1. Initial [___ / 40 = _____] 2. Follow up [_____ / 40 = _____] Clinical improvement [Total initial - Total follow-up / Total initial = _____

Primary Care Facility: _____

Contact Number: _____

Physician: _____

KOSTERMAN
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Informed Consent

We encourage and support a shared decision-making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment.

In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life. In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

KOSTERMAN
CHIROPRACTIC

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective.

Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE:

KOSTERMAN CHIROPRACTIC

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name: _____ Patient Signature: _____

Date: _____

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____