Energy Medicine & Healing Center
Patient Information

Today's Date: _____ /_____/_____

Name: _____ Age: _____ Sex: Male Female
(First) (Middle) (Last)

Date of Birth: _____/_____/_____ |

Marital Status: Married Single Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Place of Work: _____ Work Phone #: _____

Emergency Contact : _____ Relationship: _____ Phone #: _____

E-mail Address: _____ Do you give us a permission to contact you through email? Yes No

How did you find us? _____

Is your visit due to an accident? Yes No Type of Accident: Auto Work Slip/Fall Other:_____

If any of the following are relevant to your medical condition, please circle

Cancer	*Muscular dystrophy*	*Rheumatic Fiver*	*Digestive Disorders*
Polio	*Multiple Sclerosis*	*Scarlet Fever*	*Sinus Trouble*
Tuberculosis	*Convulsions*	*Nervouseness*	*Backaches*
Epilepsy	*High Blood Pressure*	*Asthma*	*Numbness*
Heart trouble	*Concussion*	*Dizziness*	*Arthritis*
Diabetes	*Hepatitis*	*German Measles*	*Venereal Disease*

Weight: _____ pounds **Height: _____** **Are you: Left Handed Right Handed**

Past History

Physician/Hospital	**Date of Illness/Accident**	**Reason**	**Did you fully recover?**
_____	_____	_____	**Yes No**
_____	_____	_____	**Yes No**

Are you currently taking any medication? Yes No What kind? _____Last Physical Exam Date: _____

Are you allergic to any medication? Yes No Please list: _____

Are you or could you be pregnant? Yes No Date of last menstrual period: _____

Do you drink alcohol? Yes No If yes, how often? _____ Do you smoke cigarette? Yes No

Do you exercise? Yes No If yes, how often? _____

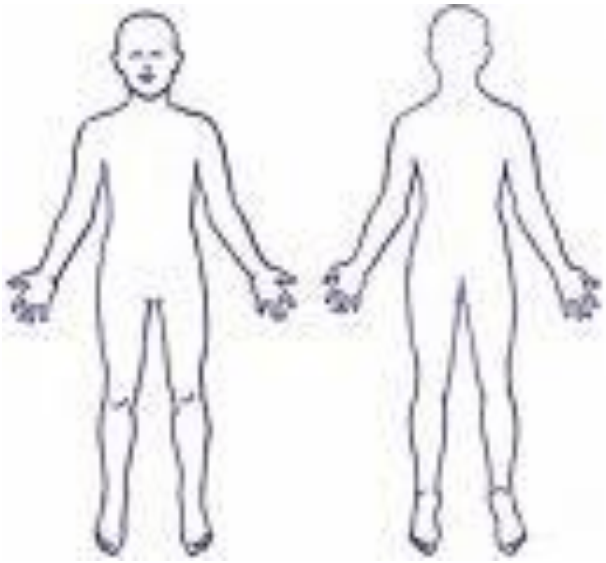
Patient Name: _____

Patient Condition

Reason for Visit: _____

When did the symptoms begin? _____

Please mark an X(s) on the body figure where you have pain:



Type of pain: **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling**

Do you have any of the following?

Headaches Muscle Spasms Dizziness Anxiety Loss of Sleep Ear Noises

Signature: _____ **Date:** _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment. In particular:

a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.

b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.

c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Dr. Chie Uekihara, D.C. will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Dated this _____ day of _____, 20____

_____	_____
Patient Signature (Legal Guardian)	Signature of Guardian (when applicable)
Name:_____	Name:_____
(Please print name of patient)	(Please print name of guardian)
Name:_____	_____