Confidential Health Information

Please allow staff to copy your picture ID and Insurance card.

Jones Chiropractic Clinic
Drs. Jones, Carruthers, & Hicks
801 E. Watauga Ave, JC, TN 37601
423-929-3700 Fax 423-929-8780
joneschiroclinic@gmail.com

Total Health and Wellness
Tom Rodgers, M.D.
Sherri White, ACNP-BC & Vicky Hudson, FNP-BC
801 E. Watauga Ave, Suite 2, JC, TN 37601
423-929-3700 Fax 423-929-8780
totalhealthandwellness2017@gmail.com

Date: ________________

Last name: ______________________ First name: ______________________

Male ☐ Female ☐ SSN: _____-_____-_____ DOB: ___/___/_____ Age: _____

Address: ______________________ City: ____________ State: ________ Zip: ________

Email address: ______________________ Home phone: ______________________

Cell Phone: ______________________ May we text you?___ Work Phone: ______________________

May we contact you at work? _____ Preferred method of contact: ______________________

Marital status: single ☐ married ☐ widowed ☐ divorced ☐ separated ☐

Spouse/Partner name: ______________________ Phone: ______________________

Do you have children?___ List their names and ages: ______________________

____

Your Occupation: ______________________ Your employer: ______________________

Employer address: ______________________ City: ____________ State: ________ Zip: ______

Whom may we thank for referring you to our office? ______________________

Have you consulted a chiropractor before? _____ If so, whom? ______________ When: __________

When was the last time your spouse/children/ partner had their spines checked? ______________

Your primary care physician: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ______

When was your last visit to your PCP? ______________________ May we contact them if needed? _____

Emergency contact: ______________________ Phone: ______________ Relationship: ____________

Insurance company: ______________________ Policy#: ______________ Group#: ____________

Insurance Address: ______________________ City: ____________ State: ________ Zip: ________

Insured's name: ______________________ Insured's DOB: ______________

Who's policy? Self ☐ Spouse ☐ Insured's Employer: ______________ Employer's Phone: ____________

Insured's Employer Address: ______________________ City: ____________ State: _____ Zip: ________

____
Doctor's Initials

____
FNP's Initials

1. **The symptom(s) that have prompted me to seek care today include:** ______________________

____

2. **And are the result of (darken circle):** ○ An accident or injury
○ Work ○ Auto ○ Other ______________________
○ A worsening long-term problem
○ An interest in. ○ Wellness ○ Other ______________________

3. **Onset** (When did you first notice your current symptoms?)
____

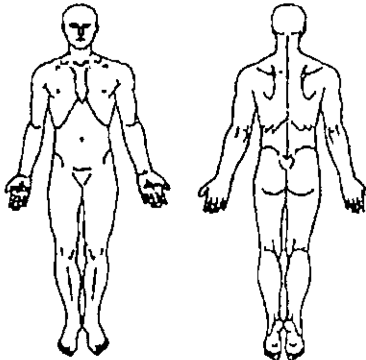
4. **Intensity** (How extreme are your current symptoms?)
0 ○○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? ______________________

____

6. **Quality of symptoms** (What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other ______________________

7. **Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experience in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ______________________
What tends to lessen the problem? ______________________

10. **Prior interventions** (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic ○ Other ______________________
○ Physical Therapy ○ Massage ______________________

11. **What else should we know about your current condition?** ______________________

____

12. **How does your current condition interfere with your:**

Work or career: ______________________

Recreational activities: ______________________

Household responsibilities: ______________________

Personal relationships: ______________________

13. **Review of Systems**

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee Injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ___

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ___

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ___

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ___

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ___

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ___

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ___

____
Patient name

Consultation Notes

____
Doctor's Initials

____
FNP's Initials

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
O	O	Thyroid issues	O	O	Immune disorders	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy	NONE O Initials __

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
O	O	Kidney stones	O	O	Infertility	O	O	Bedwetting	O	O	Prostate issues	O	O	Erectile dysfunction	O	O	PMS symptoms	NONE O Initials __

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
O	O	Fainting	O	O	Low libido	O	O	Poor appetite	O	O	Fatigue	O	O	Sudden weight gain/loss (circle 1)	O	O	Weakness	NONE O Initials __

Patient name

O All other systems negative

Past Personal, Family and Social History
Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses
Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Tuberculosis
O	O	Alcoholism	O	O	Typhoid fever
O	O	Allergies	O	O	Ulcer
O	O	Arteriosclerosis	O	O	Other ________
O	O	Cancer			________
O	O	Chicken pox			________
O	O	Diabetes			________
O	O	Epilepsy			________
O	O	Glaucoma			________
O	O	Goiter			________
O	O	Gout			________
O	O	Heart disease			________
O	O	Hepatitis			
O	O	HIV Positive			
O	O	Malaria			
O	O	Measels			
O	O	Multiple Sclerosis			
O	O	Mumps			
O	O	Polio			
O	O	Rheumatic fever			
O	O	Scarlet fever			
O	O	Sexually transmitted disease			
O	O	Stroke			

15. Operations
Surgical interventions, which may or may not have included hospitalization.

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery: ________
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spine ________
- O Tonsillectomy
- O Vasectomy
- O Other ________

16. Treatments
Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
O	O	Acupuncture
O	O	Antibiotics
O	O	Birth control pills
O	O	Blood transfusions
O	O	Chemotherapy
O	O	Chiropractic care
O	O	Dialysis
O	O	Herbs
O	O	Homeopathy
O	O	Hormone replacement
O	O	Inhaler
O	O	Massage therapy
O	O	Physical therapy
O	O	Nutritional supplements. List: ________
O	O	Medications (prescription and over-the-counter: ________

17. Injuries
Have you ever...

- O Had a fractured or broken bone
- O Had a spine or nerve disorder
- O Been knocked unconscious
- O Been injured in an accident
- O Used a crutch or other support
- O Used neck or back bracing
- O Received a tattoo
- O Had a body piercing

Consultation Notes

18. Family History
Some health issues are hereditary. Tell Jones Chiropractic about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	Poor	Illnesses	Age of death	Cause of death: Natural	Illness
Mother	____	O	O	____	____	O	O
Father	____	O	O	____	____	O	O
Sister 1	____	O	O	____	____	O	O
Sister 2	____	O	O	____	____	O	O
Brother 1	____	O	O	____	____	O	O
Brother 2	____	O	O	____	____	O	O
____	____	O	O	____	____	O	O

19. Are there any other hereditary health issues that you know about? ________

20. Social History
Tell Jones Chiropractic Clinic about your health habits and stress levels.

SOCIAL

Alcohol use	O Daily	O Weekly	How much? ________
Coffee use	O Daily	O Weekly	How much? ________
Tobacco use	O Daily	O Weekly	How much? ________
Exercising	O Daily	O Weekly	How much? ________
Pain relievers	O Daily	O Weekly	How much? ________
Soft drinks	O Daily	O Weekly	How much? ________
Water intake	O Daily	O Weekly	How much? ________
Hobbies ________			

Prayer or meditation?	O Yes	O No
Job pressure/stress?	O Yes	O No
Financial peace?	O Yes	O No
Vaccinated?	O Yes	O No
Mercury fillings?	O Yes	O No
Recreational drugs?	O Yes	O No

Doctor's Initials

FNP's Initials

Patient name

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? ____________

23. How much sleep do you average per night? ________ **Hours**

24. What is the type and approximate age of your mattress and pillow? ____________

25. What is your preferred sleeping position? ____________

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________

____

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________

____

Consultation Notes

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

Initials ____ I instruct the providers to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic/medical care offered in this procedure is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials ____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ____________

Initials ____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials ____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's name: ____________

____________ Signature

____________ Date (MM/DD/YYYY)

Doctor's Initials

FNP's Initials

Jones Chiropractic Clinic
Total Health & Wellness

Drs. Jones, Carruthers, and Hicks
Vicky Hutson, Sherri White, FNP

MRN:________________

Consent For Treatment

Total Health And Wellness· Tom Rogers, M.D. · Sherri Gayle White, ACNP-BC· Vicky Hutson, FNP-BC
801 E. Watauga Ave. Ste. 2 Johnson City, TN 37601 423-773-0300 fax 423-929-8780
www.totalhealthandwellnesstn.com totalhealthandwellness@gmail.com

General consent for treatment and test: I consent to treatment by the Total Health And Wellness physician, nurse practitioner, nurses, technicians, staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, injections, medications, exercises, modalities, muscle work, stretches, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State law requires physicians to report certain communicable diseases to the health department. _____initial

Independently practicing doctors: I understand and agree that most of the radiologists, pathologists, anesthesiologists, and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of Total Health And Wellness. I hereby authorize payment directly to the physicians. I also authorize the release of my medical information necessary to process these insurance claims. ____initial

Release from liability for leaving against medical advice: I agree that if I leave a physician's office against the advice of my physician or the Total Health And Wellness staff, then Total Health And Wellness, its personnel, and my physician are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice. ____initial

Authorization to release medical information: I authorize Total Health And Wellness and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents. ____initial

Controlled Substance Policy: It is not the policy of Total Health And Wellness to write controlled substances to our patients. Patients who require chronic pain and mental health medications will be directed to a specialist for evaluation and treatment. There is NO controlled substance kept on hand at Total Health And Wellness. ___initial

I have read and fully understand this document, and I agree to its terms.

______________________	______________________	______________________
Print patient name	signature of patient/representative	Date of birth

______________________	______________________
Staff/Witness	Date

PDR Oswestry Neck Pain Question

Jones Chiropractic Clinic
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Fax: 423-929-8780
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totalhealthandwellness2017@gmail.com

Name:___________________________________ **DOB:**_______________ **Pt#:**_______________ **Date:**_______________

PDR Oswestry Neck Pain Questionnaire: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***Please circle the ONE choice which describes your problem right now.***

Section 1- Pain Intensity
0. I have no pain at the moment
1. The pain is mild at the moment
2. The pain comes and goes and is moderate
3. The pain is moderate and does not vary much
4. The pain is severe, but comes and goes
5. The pain is severe and does not vary much

Section 2- Personal Care
0. I can look after myself without causing extra pain
1. I can look after myself normally, but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help, but manage most of my personal care
4. I need help every day in most aspects of self-care
5. I do not get undressed, I wash with difficulty and stay in bed

Section 3- Lifting
0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it causes extra pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift only very light weights
5. I cannot lift or carry anything at all

Section 4- Reading
0. I can read as much as I want to with no pain in my neck
1. I can read as much as I want to with slight pain in my neck
2. I can read as much as I want to with moderate pain in my neck
3. I cannot read as much as I want to because of moderate pain in my neck
4. I cannot read as much as I want to because of severe pain in my neck
5. I cannot read at all

Section 5- Headache
0. I have no headaches at all
1. I have slight headaches that come infrequently
2. I have moderate headaches that come infrequently
3. I have moderate headaches that come frequently
4. I have severe headaches that come frequently
5. I have headaches almost all the time

Section 6- Concentration
0. I can concentrate fully when I want to with no difficulty
1. I can concentrate fully when I want to with slight difficulty
2. I have a fair degree of difficult in concentrating when I want to
3. I have a lot of difficulty in concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to
5. I cannot concentrate at all

Section 7- Work
0. I can do as much work as I want to
1. I can do my usual work but no more
2. I can do most of my usual work, but no more
3. I cannot do my usual work
4. I can hardly do any work at all
5. I cannot do any work at all

Section 8- Driving
0. I can drive my car without any neck pain
1. I can drive my car as long as I want with slight pain in my neck
2. I can drive my car as long as I want with moderate pain in my neck
3. I cannot drive my car as long as I want because of moderate pain in my neck
4. I can hardly drive at all because of severe pain in my neck
5. I cannot drive my car at all

Section 9- Sleeping
0. I have no trouble sleeping
1. My sleep is slightly disturbed (less than 1 hour sleepless)
2. My sleep is mildly disturbed (1-2 hours sleepless)
3. My sleep is moderately disturbed (2-3 hours sleepless)
4. My sleep is greatly disturbed (3-5 hours sleepless)
5. My sleep is completely disturbed (5-7 hours sleepless)

Section 10- Recreation
0. I am able to engage in all my recreational activities, with no neck pain at all
1. I am able to engage in all of my recreational activities with some pain in my neck
2. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
3. I am able to engage in only a few of my usual recreational activities because of pain in my neck
4. I can hardly do an recreational activities because of pain in my neck
5. I cannot do any recreational activities at all

Section 11- Numeric Rating Scale (NRS)
Try and assign a number from 0 to 10 to your current pain level. If you have no Pain, use a 0. As the number get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be

0 1 2 3 4 5 6 7 8 9 10

OSW-SCORE_____**%**

P-SCORE_______

_________ **Doctors Initials** _________ **FNP Initials**

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801 E. Watauga Ave, JC, TN 37601 Ste 2

(423) 929-3700 Fax (423) 929-8780

Oswesty Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Name_______________ **DOB:**__________ **Pt#:**________ **Date:**__________

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1- Pain Intensity

0. The pain comes and goes and is very mild
1. The pain is mild and does not vary much
2. The pain comes and goes and is moderate
3. The pain is moderate and does not vary much
4. The pain comes and goes and is severe
5. The pain is severe and does not vary much

Section 2- Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain
1. I do not normally change my way of washing or dressing even though it causes some pain
2. Washing and dressing increase the pain but I manage not to change my way of doing it
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it
4. Because of the pain I am unable to do some washing and dressing without help
5. Because of the pain I am unable to do any washing and dressing without help

Section 3- Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain
2. Pain prevents me lifting heavy weights off the floor
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5. I can only lift very light weights at most

Section 4- Walking

0. I have not pain when walking
1. I have some pain on walking but it does not increase with distance
2. I cannot walk more than 1 mile without increasing pain
3. I cannot walk more than ½ mile without increasing pain
4. I cannot walk more than ¼ mile without increasing pain
5. I cannot walk to all without increasing pain

Section 5- Sitting

0. I can sit in any chair as long as I like
1. I can sit only in my favorite chair as long as I like
2. Pain prevents me from sitting more than 1 hour
3. Pain prevents me from sitting more than ½ hour
4. Pain prevents me from sitting more than 10 minutes
5. I avoid sitting because it increases pain immediately

Section 6- Standing

0. I can stand as long as I want without pain
1. I have some pain on standing but it does not increase with time
2. I cannot stand for longer than 1 hour without increasing pain
3. I cannot stand for longer than ½ hour without increasing pain
4. I cannot stand longer than 10 minutes without increasing pain
5. I avoid standing because it increases the pain immediately

Section 7- Sleeping

0. I get no pain in bed
1. I get pain in bed but it does not prevent me from sleeping well
2. Because of pain my normal nights sleep is reduced by less than one-quarter
3. Because of pain my normal nights sleep is reduced by less than one-half
4. Because of my pain my normal nights sleep in reduced by less than three-quarters
5. Pain prevents me from sleeping at all

Section 8- Social Life

0. My social life is normal and gives me no pain
1. My social life is normal but it increases the degree of pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of the pain

Section 9- Traveling

0. I get not pain when traveling
1. I get some pain when traveling but none of my usual forms of Travel make it any worse
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel
3. I get extra pain while traveling which compels to seek alternative forms of travel
4. Pain restricts me to short necessary journeys under ½ hour
5. Pain restricts all forms of travel

Section 10- Changing Degree of Pain

0. My pain is rapidly getting better
1. My pain fluctuates but is definitely getting better
2. My pain seems to be getting better but improvement is slow
3. My pain is neither getting better or worse
4. My pain is gradually worsening
5. My pain is rapidly worsening

____
Doctor's Initials

TOTAL: ________

____
FNP's initials

Name:__________________________ DOB:____________ Pt#:____________ Date:________

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

- Physical examination – ultrasound therapy – laser therapy – palpation – postural analysis – hot/cold therapy – traction/decompression – rehabilitation – vital signs – diagnostic studies – electrical muscle stimulation – bracing and support applications – manual therapy – acupuncture/dry needling

The material risks associated with chiropractic treatment
Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring
Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following
There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain killer
- Hospitalization/Surgery

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatments, making it more difficult and less effective the longer it is postponed.

(Cont)

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Dr. Jones, Carruthers, and Eldridge will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgements based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate and error in judgment or treatment.
4. Dr. Jones or Eldridge does not guarantee any results with respect to any course of care or treatment.

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.

Patient:

I [ ] have read, or [ ] have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize Dr. Jones or Eldridge and his/her assistants, associates and other appropriate persons to render care, to perform and examination and to provide and appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. Jones or Eldridge and have had my inquiries answered to my satisfaction.

By signing below, I state that I have weighed the risks and /or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

__________________________ Patient's Name

__________________________ Date

__________________________ Patient's Signature

__________________________ Signature of Parent/ Guardian (if patient is a minor)

Jones Chiropractic Clinic
Drs. Jones, Carruthers, and Hicks
801 E. Watauga Avenue
Johnson City, TN 37601
423-929-3700