CopperWell Chiropractic
5069 W 13400 S Ste 100 Herriman UT 84096

First Name: _____ Last Name:_____

Email: _____Cell: (____)_____

Home Address: _____City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Sex: Male Female

How did you Hear about us?_____

Family Doctor:_____ Emergency Contact:_____

List all Medications you are currently taking and what it is prescribed for:

List all Supplements you are currently taking and for what conditions:

List all known allergies:

List all health conditions you have been treated for over the last year and your treating physician:

Please check all options you currently or previously have experienced:

- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Bronchitis
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/Tightness
- [ ] Circulation Problems
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Coughing Blood
- [ ] Depression
- [ ] Diabetes
- [ ] Difficulty Urinating
- [ ] Digestion Problems
- [ ] Epilepsy/Seizures
- [ ] Frequent Colds
- [ ] Gout
- [ ] Headaches
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disk
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hypoglycemia
- [ ] Irregular Heart Beat
- [ ] Irregular Cycle
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Liver Disease
- [ ] Loss of Memory
- [ ] Loss of Balance
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Low Blood Pressure
- [ ] Migraines
- [ ] Multiple Sclerosis
- [ ] Muscle Spasms
- [ ] Neck Pain/Stiffness
- [ ] Nosebleeds
- [ ] Numbness in Fingers
- [ ] Numbness in Toes
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Parkinson's Disease
- [ ] Pinched Nerve
- [ ] Psychiatric Care
- [ ] Rheumatoid Arthritis
- [ ] Ringing of the Ears
- [ ] Sciatica
- [ ] Sinus Infection
- [ ] Sleeping Problems
- [ ] Spinal Curvature
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Problems
- [ ] Tumors
- [ ] Varicose Veins
- [ ] Weakness in Extremity,ities
- [ ] Weight Gain/Loss
- [ ] Other Conditions Diagnosed by a Doctor

Explain checked boxes as needed:

Check all that apply to your personal medical history and explain in the space provided:

- [ ] Broken Bones
- [ ] Been hospitalized
- [ ] Been struck unconscious/fainting/dizziness
- [ ] Had Surgery
- [ ] Fainted/Passed Out

Do you have any family members that have been diagnosed with the following? (explain in the space provided)

- [ ] Arthritis
- [ ] Cancer
- [ ] Diabetes
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Other

Please Explain your reason for seeking treatment and when symptoms begun:

Pain Scale in the Last 24 hours: 1 2 3 4 5 6 7 8 9 10

Pain Scale in the last Week: 1 2 3 4 5 6 7 8 9 10

What best describes your pain? Check all that apply.

☐ Aching ☐ Shooting ☐ Sharp ☐ Burning ☐ Numb ☐ Tender ☐ Stabbing ☐ Throbbing ☐ Miserable
☐ Unbearable ☐ Exhausting

What time of day is your pain the worst?

☐ Morning upon arising ☐ Later in the morning ☐ Afternoon ☐ Evening ☐ Night ☐ Bedtime
☐ Pain Always the Same ☐ Varies

What makes your pain BETTER? Check all that apply.

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Pain Medication ☐ Massage ☐ Exercise ☐ Walking
☐ Laying Down ☐ Standing ☐ Sitting ☐ Sleeping ☐ Biofreeze ☐ Physical Therapy ☐ Decompression
☐ Chiropractic Adjustments

What makes your pain WORSE? Check all that apply.

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Pain Medication ☐ Lifting ☐ Massage ☐ Exercise ☐ Walking
☐ Standing ☐ Sitting ☐ Work ☐ Laying Down ☐ Sleeping ☐ Physical Therapy ☐ Decompression
☐ Chiropractic Adjustments

How often are you experiencing your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

TRANSACTIONAL EMAILS

_____**(INITIAL)** I would like to opt in to receive emails to keep me informed on new bookings, changes to my bookings and reminders for upcoming appointments.

ACCURACY OF INFORMATION

_____**(INITIAL)** I certify that the above medical information is correct to my knowledge.

PRIVACY AND SHARING OF INFORMATION

_____**(INITIAL)** I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

CANCELATION POLICY

_____**(INITIAL)** Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the providers' day that could have been filled by another patient. As such, **we require 36 hours notice for any cancellations** or changes to your appointment. **Patients who provide less than 36 hours notice, or miss their appointment, will be charged a cancellation fee that must be paid prior to rescheduling.**

INFOMRATED CONSENT

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 receive the care.
We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our 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.
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 typed 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,

including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocation, 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 no 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 dissection 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 one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use form major GI events of the entire (upper and lower) GI tract 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 far any future condition(s) for which I seek chiropractic care from this office

SIGNATURE:_____DATE:_____

IF USING INSURANCE:

INSURNACE COMAPNY:_____

ID OR POLICY #:_____

PLEASE PROVIDE YOUR CARD FOR US TO MAKE A COPY