



**PATIENT INFORMATION FORM**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: (a) Male (b) Female

Marital Status: (a) Single (b) Married (c) Other \_\_\_\_\_

Work Status: (a) employed (b) part-time student (c) full-time student (d) other

Employer (if applicable) \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Is it ok to contact you at work? (Y/N) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

Have you seen a chiropractor before? (Y/N) \_\_\_\_\_

**Informed Consent Waiver and Authorization to Treat**

I the undersigned, acknowledge by my signature, that I am aware that the IST practitioner is a licensed chiropractic physician and although rare, injury from treatment or manipulation may have affects that may include stroke, disc herniation and/or other injuries or complications.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent or Guardian if patient is under 18 \_\_\_\_\_

Date \_\_\_\_\_

\* If you find it impossible to keep a scheduled appointment, please avoid the charge for a visit by canceling at least 24 hours in advance.



**PATIENT HISTORY**

What are your chief symptoms or medical problems at this time? \_\_\_\_\_

Please list any other medical problems or areas of pain and discomfort.

**MEDICAL HISTORY**

Please list any significant medical illnesses or diagnoses given to you by a physician. Check the box if you were hospitalized for the condition.

\_\_\_\_\_

\_\_\_\_\_

Age of mattress \_\_\_\_\_  Comfortable  Uncomfortable

Are you wearing  heel lifts  soles lifts  inner soles (orthotics)

Were you in a motor vehicle accident? \_\_\_\_\_ Personal Injury? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

**SURGICAL HISTORY**

Operation \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_

Operation \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_

Operation \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_

**EXERCISE**

Type \_\_\_\_\_ Hours per day \_\_\_\_\_ Days per week \_\_\_\_\_

**SITTING**

Computer – hours per day \_\_\_\_\_ TV – hours per day \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication _____	Dosage _____	Frequency _____
Medication _____	Dosage _____	Frequency _____
Medication _____	Dosage _____	Frequency _____
Medication _____	Dosage _____	Frequency _____
Medication _____	Dosage _____	Frequency _____

**CURRENT SUPPLEMENTS**

Supplements _____	Dosage _____	Frequency _____
Supplements _____	Dosage _____	Frequency _____
Supplements _____	Dosage _____	Frequency _____
Supplements _____	Dosage _____	Frequency _____
Supplements _____	Dosage _____	Frequency _____

**FAMILY HISTORY**

Has anyone in your family had any of the following: (Put an **M** for mother, **F** for father, and **B** for both)

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer or Stomach Problems  |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Stroke (Please indicate age when stroke occurred,<br>Mother _____ Father _____ ) |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Arthritis-Rheumatism   |
| <input type="checkbox"/> Seizure-Convulsions | <input type="checkbox"/> Mental Illness   |
| <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Circulation Problems   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Kidney Disease      |   |

**GENERAL**

Are you seeing any other doctor now for any reason? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you frequently ill? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you having fever, chills or sweats? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you lost or gained weight recently? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have loss of appetite? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you experiencing fatigue? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been diagnosed with or thought your might have Lyme Disease? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many per day? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many drinks per day? \_\_\_\_\_

## NOSE & THROAT

- Have you had sinus trouble? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you had hay fever? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you had hoarseness or change in voice? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have significant alteration in taste or smell? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have nasal polyps? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have history of thyroid disease? Yes \_\_\_\_\_ No \_\_\_\_\_

## CHEST

- When was your last chest x-ray? \_\_\_\_\_ Was it abnormal? \_\_\_\_\_
- Have you had asthma or wheezing? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have shortness of breath at rest? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have shortness of breath with exertion? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have shortness of breath at night? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a frequent cough? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you ever cough up blood? Yes \_\_\_\_\_ No \_\_\_\_\_

## HEART

- When was your last electrocardiogram? \_\_\_\_\_  
Was it abnormal? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have elevated cholesterol? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever suffered a heart attack? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any chest pain or discomfort? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever had ankle or leg swelling? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you bothered by thumping, racing or skipping of the heart? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever been told that you have a heart murmur? Yes \_\_\_\_\_ No \_\_\_\_\_

## GASTROINTESTINAL

- Do you have trouble swallowing? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have heartburn? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you troubled by nausea or vomiting? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have abdominal pain? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been diagnosed as having an ulcer? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been diagnosed as having Gallbladder disease? Yes \_\_\_\_\_ No \_\_\_\_\_

When was your last sigmoidoscopic exam?  
Were colon polyps found? Yes \_\_\_\_\_ No \_\_\_\_\_

### **GENITOURINARY**

Have you ever been bothered by frequent urination? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a history of bladder or kidney infection? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have trouble starting or stopping urine flow? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you sometimes lose control of your bladder? Yes \_\_\_\_\_ No \_\_\_\_\_

### **BONES & JOINTS**

Do you have joint pain or stiffness? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have osteoporosis? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have muscle weakness? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have muscle tenderness? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you get muscle cramps with walking? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you get muscle cramps at night? Yes \_\_\_\_\_ No \_\_\_\_\_

### **NEUROLOGICAL**

Are you having severe headaches? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had fainting or loss of consciousness? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a seizure or convulsion? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you ever bothered by a spinning sensation or vertigo or lightheadedness? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a balance problem? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have difficult walking? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you experience numbness or tingling in your arms or legs? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any weakness in your arms or legs? Yes \_\_\_\_\_ No \_\_\_\_\_

# PAIN

Please mark on the diagram the type of pain and location:

## TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

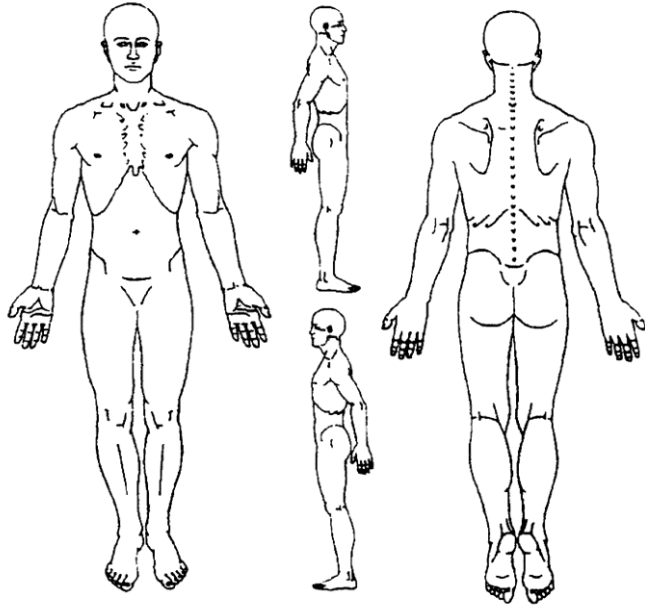
Place appropriate symbol or letter on the diagram.

- Ache = A
- Numbness = N
- Pins and Needles = O
- Burning = X
- Stabbing = /

## WHAT IS THE INTENSITY OF YOUR PAIN?

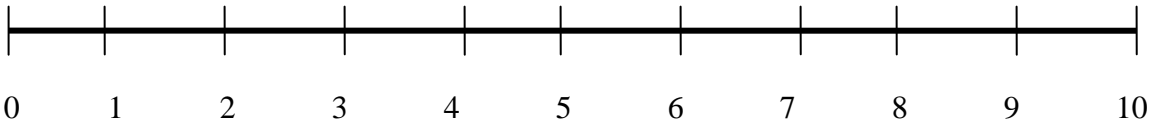
Please circle one...

- |                 |                |
|-----------------|----------------|
| <b>Slight</b>   | <b>Minimal</b> |
| <b>Moderate</b> | <b>Severe</b>  |



## NUMERICAL RATING SCALE

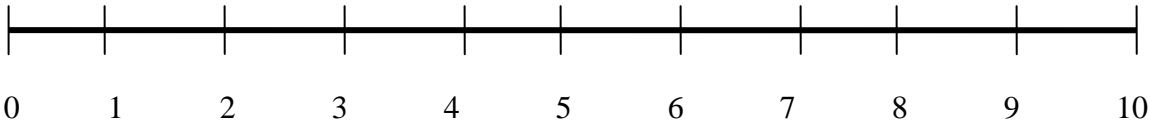
Please place a mark on the line that corresponds to your *current* pain for this condition (0 = No Pain, 10 = Worst Pain Ever).



NO PAIN

WORST PAIN EVER

Please place a mark on the line that corresponds to your *worst* pain for this condition (0 = No Pain, 10 = Worst Pain Ever).



NO PAIN

WORST PAIN EVER

When did the pain begin? \_\_\_\_\_ Any flare-ups since then? If yes, when? \_\_\_\_\_

What brought the pain on? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

How often does the pain exist? \_\_\_\_\_ And for how long? \_\_\_\_\_

Any prior injuries? \_\_\_\_\_

Have you seen another healthcare practitioner for the pain/condition? \_\_\_\_\_

If so, who? \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Consent for Use or Disclosure of Health Information

### Integrated Sports Therapy (IST), PC Privacy Pledge

IST is very concerned with protecting your privacy. While the law requires IST to give you this disclosure, please understand that IST will always respect the privacy of your health information.

There are several circumstances in which IST may have to use or disclose your health care information.

- IST may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- IST may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- IST may need to use your health information within our practice for quality control or other purposes.

IST has a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (notice 164.520). IST reserves the right to change its privacy practices as described in that notice. If IST makes a change to its privacy practices, IST will notify you in writing when you come in for treatment or by mail. Please feel free to call IST anytime for a copy of its privacy notices.

#### Your right to limit uses or disclosures

You have the right to request that IST does not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let IST know in writing. IST is not required to agree to your restrictions. However, if IST agrees with your restrictions, the restriction is binding to IST.

#### Your right to revoke your authorization

You may revoke your consent to IST at any time; however, your revocation must be in writing. IST will not be able to honor your revocation request if IST has already released your health information before IST receives your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

**I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.**

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Signature of Chiropractic Physician

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## GRASTON TECHNIQUE QUESTIONNAIRE AND INFORMED CONSENT

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Please answer the following questions (Yes/No). Read the statements concerning Graston Technique, and sign below. If you have any questions, please ask your IST practitioner.

1. Do you bruise easily? \_\_\_\_\_
2. Do you bleed for a long period of time after you cut yourself? \_\_\_\_\_
3. Are you taking blood thinners or anticoagulants? \_\_\_\_\_
4. Do you take aspirin on a regular basis? \_\_\_\_\_
5. Do you take cortisone on a regular basis? \_\_\_\_\_
6. Have you ever had inflamed veins or blood clots? \_\_\_\_\_
7. Do you have surgical implants in your body? \_\_\_\_\_
8. Do you have diabetes or kidney disease? \_\_\_\_\_
9. Do you currently have any infections? \_\_\_\_\_
10. Do you have uncontrolled high blood pressure? \_\_\_\_\_

Graston Technique is an instrument assisted variation of traditional cross fiber or transverse friction massage. The Graston Technique instruments consist of six stainless steel tools of various sizes and contours. Graston Technique is a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment
2. Reddening of the skin
3. Superficial tissue bruising
4. Post treatment soreness

Graston Technique is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

Graston Technique has several basic components. The IST practitioner will determine the protocol for each patient individually.

1. Graston Technique Instrument Assisted Soft-Tissue Manipulation
2. High repetition, low load exercise
3. Home stretches for treatment areas
4. Low repetition, high weight exercise
5. Stretching / rehabilitation exercises

**All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.**

Your signature \_\_\_\_\_ Date \_\_\_\_\_