Case History

Patient Information

Name_____
Date _____
Mailing Address_____
City _____ State_____ Zip_____
Social Security #_____
Date of Birth_____ Age_____
Email_____
Occupation_____
Employer_____
Marital Status: Single Married Divorced Widowed Separated
Spouse Name_____
Spouse's Occupation_____
Number of Children/Ages_____
Have you ever received Chiropractic Care? Yes No
Who can we thank for referring you? _____

Accident Information

Is your condition due to an accident? Yes No
Type of accident: Auto Work Home Other
Who have you reported this accident?
Insurance Employer Attorney Other

Phone Numbers

Home/Cell_____
Notifications: Cell o Email o Both o
In case of emergency, contact:
Name _____
Phone 1 _____
Phone 2 _____

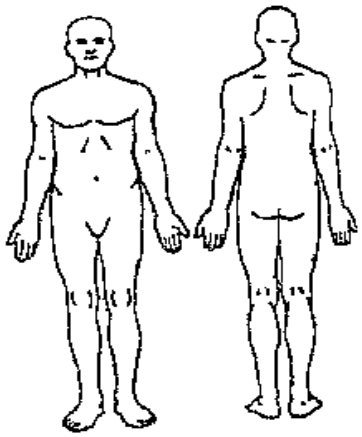
Insurance

We do not bill 3rd party or private insurance directly. We will provide a superbill that you can submit for reimbursement.

By signing this, I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information regarding my records and authorize the use of this signature on all insurance submissions if ever necessary.

Patient Condition

Reason for Seeking Care: _____ Is it for: O Pain Relief / O Corrective Care / O Maintenance
When did your symptoms start? _____
Pains are: O Constant O Come and Go O Other_____
Pains are: O Sharp O Dull O Other_____
Does this pain shoot, radiate, or travel in your body? Where? _____
Are you experiencing numbness or tingling in any area of your body? Where? _____
What activities aggravate your condition? _____
What activities lessen your condition? _____
Is this condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition progressively getting worse? _____
Rate the severity of your condition (No Complaint) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)
Other Doctors seen for this condition _____
Any Home remedies? _____
Place an "X" on the picture where you are experiencing pain:



Past Health History

Please mark any of the following that you have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus Problems	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Asthma	O Weight Loss	O Allergies

Medications	**Allergies**	**Vitamins/Supplements**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently under drug and medical care? _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Please List any Injuries/Surgeries you have had:

Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Surgeries _____

Exercise	**Work Activity**	**Habits**
None	Sitting	Tobacco
Moderate	Standing	Alcohol
Heavy	Light Labor	Caffeine
Daily	Heavy Labor	High Stress

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Relief Care**, which corrects the most recent layer of Spinal and Neurological damage. This care often reduces or eliminates the symptoms. Then begins **Corrective Care,** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care (Maintenance)**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature_____Date_____

Riemer Chiropractic

Dr. Shane Riemer, D.C., CSCS

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Clinic: (806) 359-4360

Informed Consent to Chiropractic Care / Terms of Acceptance

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column causing interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to express its maximum potential.
Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation.

Chiropractic has only one goal, the correction of the vertebral subluxation to restore the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

When the Doctor gives an adjustment, the Doctor will use his hands or a mechanical device upon your body in such a way to restore motion to the joints. Sometimes this may cause an audible "pop" or "click", like when you "crack" your knuckles. You may even feel a sense of movement. The Adjustment is our tool to facilitate the body's natural ability to heal itself.

We do not offer to diagnose or treat any disease of condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our method is the chiropractic adjustment.

As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Fractures are rare occurrences and generally result from some underlying weakness of the bone that we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement with a 1-in-8-million chance of occurrence. Since even that risk should be avoided if possible, we employ tests in our examinations that are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

In addition to Chiropractic adjustments, we may use the following treatments:

Cryotherapy (cold packs) - risk of skin reactions
Trigger Point Therapy - risk of bruising, release of emboli
Massage - risk with deep vein thrombosis, bruising, muscle soreness

The risks and dangers attendant to remaining untreated: Remaining untreated allows the formation of adhesions and reduces mobility that sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Your health is very important to us. We want to give you the very best care possible, so if you experience any problems please let us know. Some patients may feel some stiffness and soreness following the first few days of treatment. This is normal as the body adapts to the changes we make, but feel free to ask the doctor about any discomforts or changes you experience. Together we can focus on your maximum potential.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the Doctor of Chiropractic named above. I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo treatment recommended.

Printed Name of Patient :_____Signed Name and Date:_____ /_____
Parent and/or Guardian