Robert A. Davison, D.C., C.C.S.T

2500 Martin Luther King, Jr. Way • Berkeley • CA 94704-2613
Tel (510)843-2584 Fax (510)843-2591

BACK IN ACTION

Name: _____ Prefer to be called: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ e-mail Address: _____

Age: _____ Date of Birth: _____

Number of Children: _____ Ages: _____

Occupation: _____ Employer _____

Address: _____ City, State, Zip: _____

Office Phone #: _____ Cell Phone/Pager: _____

Name of Spouse/Partner: _____

Occupation: _____ Employer: _____

In case of emergency, please contact: _____ Relationship: _____

Phone Number: _____ Address: _____

Referred to Back In Action by: _____

Is condition due to illness or injury arising out of patient's employment? ❑ Yes ❑ No

If yes, describe: _____

Any days from work lost due to condition? _____ Date of last physical exam: _____

Females: Are you Pregnant? ❑ Yes ❑ No

Ever been under chiropractic care before? ❑ Yes ❑ No; Chiropractor's name: _____

Address, Phone Number: _____

Have you seen any other chiropractors, MD's, acupuncturists or other health care providers for this condition? ❑ Yes

❑ No

Name: _____ Phone: _____

Name: _____ Phone: _____

Robert A. Davison, D.C., C.C.S.T

BACK IN ACTION CHIROPRACTIC CENTER

Patient Intake Form Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Mark (c) for current problems, check❑ and indicate the age when you had any of the following:

General:
- ❑ Allergies
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Headaches
- ❑ Loss of sleep
- ❑ Mental illness
- ❑ Nervousness
- ❑ Tremors
- ❑ Weight loss/gain

Muscle/Joint:
- ❑ Arthritis/rheumatism
- ❑ Bursitis
- ❑ Foot trouble
- ❑ Muscle weakness
- ❑ Low back pain
- ❑ Neck pain
- ❑ Mid back pain
- ❑ Joint pain

Skin:
- ❑ Boils
- ❑ Bruise easily
- ❑ Dryness
- ❑ Hives or allergies
- ❑ Itching
- ❑ Rash
- ❑ Varicose veins

Eye, Ear, Nose & Throat:
- ❑ Colds
- ❑ Deafness
- ❑ Ear ache
- ❑ Eye pain
- ❑ Hoarseness
- ❑ Nasal obstruction
- ❑ Nose bleeds
- ❑ Ringing of the ears
- ❑ Sinus infection
- ❑ Sore throat
- ❑ Tonsillitis
- ❑ Vision problems

Gastrointestinal:
- ❑ Abdominal pain
- ❑ Bloody or tarry stool
- ❑ Colitis/Crohn's
- ❑ Colon trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficult digestion
- ❑ Diverticulitis
- ❑ Bloated abdomen
- ❑ Excessive hunger
- ❑ Gallbladder trouble
- ❑ Hernia
- ❑ Jaundice
- ❑ Liver trouble
- ❑ Nausea
- ❑ Painful defecation
- ❑ Pain over stomach
- ❑ Poor appetite
- ❑ Vomiting
- ❑ Vomiting of blood

Genitourinary:
- ❑ Bladder infection
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Prostate trouble
- ❑ Stress incontinence Urination:
- ❑ Overnight more than twice
- ❑ More than 8x in 24hrs
- ❑ Decreased flow/force
- ❑ Painful urination
- ❑ Urgency to urinate

Cardiovascular:
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Hardening of the arteries
- ❑ Irregular pulse
- ❑ Pain over heart
- ❑ Palpitation
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ Swelling of ankles

Respiratory:
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Hay fever
- ❑ Shortness of breath
- ❑ Spitting up phlegm/blood
- ❑ Wheezing

Women only:
- ❑ Menopause

Menstrual flow:
❑ Reg. ❑ Irreg. ❑
Pain/cramps
Days of flow:_
Length of cycle:_____

Check any of the conditions you have or have had:
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chicken pox
- ❑ Cold sores
- ❑ Diabetes
- ❑ Eczema
- ❑ Edema
- ❑ Epilepsy
- ❑ Gout
- ❑ Heart burn
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High cholesterol
- ❑ HIV/AIDS
- ❑ Influenza
- ❑ Measles
- ❑ Multiple sclerosis
- ❑ Numbness/tingling
- ❑ Pace maker
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Ulcers

Please list any medication you are currently taking and why:_____

_____

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: _____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

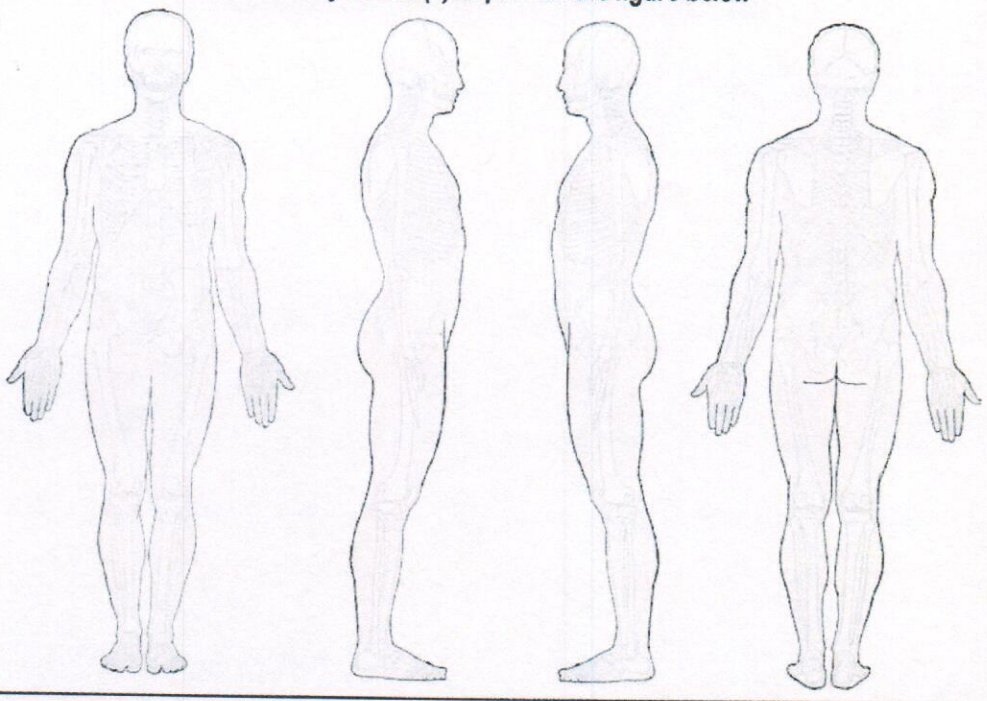
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- □ Alcoholism
- □ Anemia
- □ Arteriosclerosis
- □ Arthritis
- □ Asthma
- □ Bleed easily
- □ Cancer
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Heart disease
- □ High blood pressure
- □ High cholesterol
- □ Multiple sclerosis
- □ Osteoporosis
- □ Stroke
- □ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Back in Action Chiropractic
2500 Martin Luther King Jr. Way
Berkeley, CA 94704
(510)843-2584

Informed Consent to Chiropractic Care

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary procedure used at the Back in Action Chiropractic is the Chiropractic Adjustment. We will use our hands or a mechanical instrument in such a way as to move or affect your bones and joints. This may cause an audible "pop" or "click" or you may feel a sense of movement. This type of care has been very beneficial to many who have sought chiropractic care.

Chiropractic Care

Prior to receiving chiropractic care at Back in Action Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

As a part of your care you are consenting to the following procedures if recommended by the doctor:

__Chiropractic Adjustment
__Hot/cold therapy
__Cranial-Sacral Therapy
__Dietary Recommendations
__Massage/Soft Tissue Massage
__Exercise/rehabilitation exercise

The Material Risks Inherent in Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition or disc injury, dislocations, muscle strain, cervical myelopathy, fractures, rib separations/strains, and burns. Some patients will feel some stiffness and soreness following the first few day of care. Please let us know if you experience any of these signs or symptoms.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the examination process. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical (neck) adjustments (less than in the general population). The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

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

If you chose to use or consider one of the above noted treatment options, you should be aware that there are risks associated with each and we recommend you discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated or Without Care

Continuing without care may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this may complicate your condition making care more difficult and less effective. The longer you are in an unhealthy state without change, the more likely your health and well-being will deteriorate.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of chiropractic care at the Back in Action Chiropractic. I have discussed this with Dr. Davison or Dr._____ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and potential benefits involved and consent to the care as recommended. Having been informed of the risks and potential benefits, I hereby give my consent to care.

_____
Patient Name (printed)

_____
Doctor's Name

_____
Patient or legal Guardian Signature

_____
Doctor's Signature

Dated: _____

Dated: _____

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Financial Policy—General

Please remember, you are responsible for all bills incurred here in the office.

Routine Visits:

Full payment is required at the end of each and every visit. We are happy to offer a "prompt pay" discount.

If at any time you have questions and wish to consult the doctor with regards to your care here, please contact the front desk for a complimentary consult.

If your treatment series requires progress evaluations and re-examinations as determined by the doctor, keep in mind that additional fees may apply.

Your initial examination fee also includes the cost of the examinations for your children under 12 years old. We do this as a service for our patients because we believe in the value of preventative care.

Penalties: Interest will be charged on overdue accounts after 30 days. Interest accumulates at 1.5% per month.

Phones: Please refrain from using your cell phone while in our office. If you must take a phone call please step outside to do so.

Perfumes: Please try and avoid wearing strong perfumes and colognes as some patient are sensitive to fragrances.

Cancellations & appointment changes:

Chiropractic appointments: ***changes or cancellations received with less than 24 hour notice must be rescheduled to the next available appointment day or a missed visit charge will incur.***

Bodywork appointments: ***24 hours notice is required for canceling or changing appointments or a missed visit charge will incur. Changes or cancellations to a Saturday, Sunday or Monday appointment must be done by 5pm of the previous Friday.***

I, the undersigned, understand and will abide by all portions of this policy.

_____ _____

Signature Date