

**PLEASE DO NOT SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN  
REVIEWED WITH YOU BY YOUR DOCTOR**

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
<b>GENERAL</b>		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractor care?	<input type="checkbox"/>	
<b>BONE WEAKNESS</b>		
Have you been diagnosed with osteoporosis?	<input type="checkbox"/>	
Do you take corticosteroids (e.g. prednisone)?	<input type="checkbox"/>	
Have you been diagnosed with a compression fracture(s) of the spine?	<input type="checkbox"/>	
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	
Do you have any metal implants?	<input type="checkbox"/>	
<b>VASCULAR WEAKNESS</b>		
Do you take aspirin or other pain medication on a regular basis?	<input type="checkbox"/>	
If yes, about how much do you take daily? -----		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?		
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid arthritis	<input type="checkbox"/>	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	<input type="checkbox"/>	
• Giant cell arteritis (temporal arteritis)	<input type="checkbox"/>	
• Osteogenesis imperfect	<input type="checkbox"/>	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	<input type="checkbox"/>	
• Medial cystic necrosis (cystic mucoid degeneration)	<input type="checkbox"/>	
• Bechet's disease	<input type="checkbox"/>	
• Fibromuscular dysplasia	<input type="checkbox"/>	
Have you ever become dizzy or lost consciousness when turning your head?		
<b>SPINAL COMPROMISE OR INSTABILITY</b>		
Have you had spinal surgery?	<input type="checkbox"/>	
If yes, when? -----		
Have you been diagnosed with spinal stenosis?	<input type="checkbox"/>	
Have you been diagnosed with spondylolithesis?	<input type="checkbox"/>	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	<input type="checkbox"/>	
• Numbness in the genital area?	<input type="checkbox"/>	
• Recent inability to urinate or lack of control when urinating?	<input type="checkbox"/>	
I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.		
PATIENT [or PARENT/ GUARDIAN] SIGNATURE -----	DATE-----	
INTERN SIGNATURE -----	DATE-----	
DOCTOR'S SIGNATURE -----	DATE-----	