Chiropractic Offices of Gonstead, Stangl & Arkowski, LLCs

▫ Dr. MJ Gonstead ▫ Dr. Melissa Stangl ▫ Dr. Lisa Arkowski ▫ Dr. Jennifer Gonstead

503 E. Clairemont Avenue ◆ Eau Claire, WI 54701 ◆ 715–832–2223

PATIENT UPDATE

Patient Name		**Birth Date**
Address		
City	State	Zip
Phone (H)	Phone (C)	Phone (W)
Email Address		
Marital Status	Spouse's Name	Children ▫ yes ▫ no
Emergency Contact		Phone
Employer		Phone

▫ **CHECK HERE if you do NOT have insurance that covers chiropractic services**		
Insurance Company		
Policy #	Group #	
Please fill out the information below if you are NOT the primary insurance holder		
Name of Primary		Birth Date
Primary's relationship to you	Primary's Phone #	
Primary's Address		
City	State	Zip
Primary's Employer	Employer's Phone	
Do you have a Secondary Insurance ▫ yes ▫ no		
Secondary Policy #	Secondary Group #	
Please provide our staff with your insurance card(s) so they can take a photo copy		

INFORMED CONSENT

By signing below, I do hereby give my consent to the performance of conservative noninvasive chiropractic treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows; Soreness, dizziness, fractures/joint injury, stroke and physical therapy burns. I understand the probability of any of these risks occurring is rare and that tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks. I am aware that reasonable alternatives to chiropractic procedures are available to me including rest, home applications of therapy, prescription or over–the–counter medications, exercises, and possible surgery. I also understand that there are beneficial effects associated with chiropractic treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person(s) of the doctor's choosing. I have read or have had read to me the above explanation of chiropractic treatment. Any question I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely

Patient Signature	Date
Staff Signature	Date

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DATE

Patient Name	Birth Date

HISTORY OF PRESENT COMPLAINT

Is your present complaint due to any of the following;
▫ Auto Accident ▫ Work Injury ▫ Personal Injury ▫ Other_____

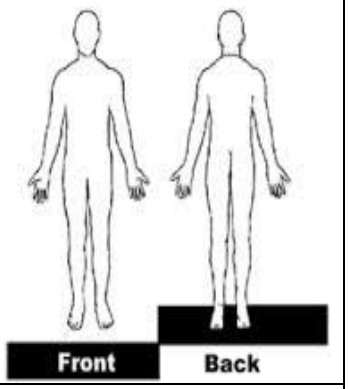
During the past 12 months, have you had any of the following;
▫ Accidents ▫ Falls ▫ Injuries ▫ Surgeries ▫ Hospitalizations ▫ New Diagnosis ▫ Major Life Event

Please describe your current complaint/concern

When did it start?

What Caused/Provoked it?

Describe the LOCATION of your complaint and mark the diagram →



Describe quality of your complaint. (What does it feel like?)

▫Ache ▫Sore ▫Tight ▫Burning ▫Pinch ▫Stab ▫Sting ▫Stiff
▫Constricted ▫Cramping ▫Numb ▫Tingling ▫Throbbing

Do/Are your pain/symptom(s) ▫ Localized/Stay in one spot ▫ Radiate/Travel ▫ Generalized/Regional

Is/Are the pain/symptoms getting ▫Better ▫Worse ▫Not changing

How severe is/are your pain/symptoms?	How frequent is/are your pain/symptoms?
▫ Minimal (NO impairment)	▫ Intermittent (0-25%)
▫ Slight (some impairment)	▫ Occasional (25-50%)
▫Moderate (ADLs difficult/painful)	▫ Frequent (50-75%)
▫Marked (preclude activity)	▫ Constant (75-100%)

What makes the pain/symptoms BETTER

What makes the pain/symptoms WORSE

What activities of daily living does/do the pain/symptoms make difficult or keep you from doing.
Be specific if possible

▫None ▫Self Care ▫ Work ▫Child Care ▫House Work ▫ Yard Work ▫Exercise ▫Recreation ▫Social Life

Patient Signature	Date