Dr. Victoria L. Welch, DC

NEW PATIENT REGISTRATION FORM

NAME (LAST, FIRST, MIDDLE INIT.)_____

ADDRESS (STREET)_____

(CITY, STATE, ZIP)_____

PHONE: HOME _____ CELL _____ DO YOU HAVE MEDICARE? YES NO

DATE OF BIRTH (MM/DD/YY) _____EMAIL_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT _____ PHONE _____

EMPLOYER (COMPANY NAME) _____ OCCUPATION _____

REASON FOR YOUR VISIT TODAY _____

_____

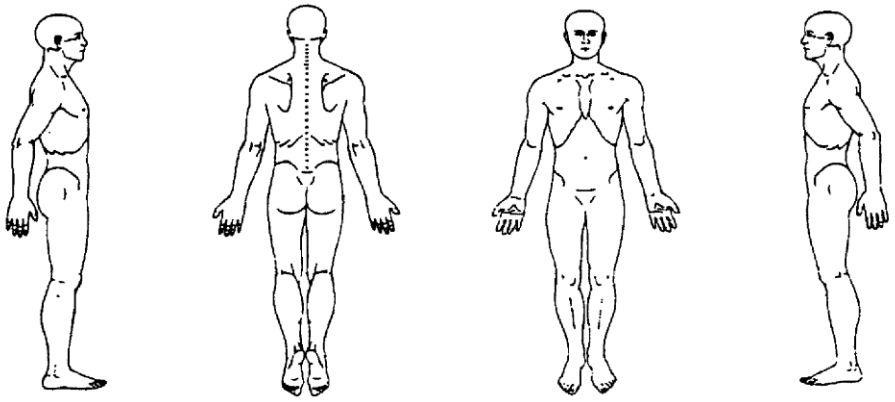
_____

WHEN DID THE SYMPTOMS FIRST APPEAR? _____

DID THESE SYMPTOMS FOLLOW AN EVENT OR TRAUMA? YES NO UNKNOWN

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES NO UNKNOWN

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN, NUMBNESS, OR TINGLING



WHAT IS THE SEVERITY OF THE PAIN? (Little or no pain, moderate, severe) _____

WHAT TYPE OF PAIN IS IT? (Sharp, burning, shooting, etc.) _____

DOES THE PAIN SEEM TO START SOMEWHERE AND RADIATE TO ANOTHER AREA? _____

IS THE PAIN INTERMITTENT OR CONSTANT? _____

DOES THE PAIN HAPPEN AT A CERTAIN TIME OF DAY? IF SO, WHEN? _____

DOES THE PAIN INTERFERE WITH WORK, SLEEP, OR DAILY ROUTINE? _____

LIST ANYTHING THAT DECREASES THE PAIN (Heat, ice, medications, stretching, etc) _____

_____

LIST ANYTHING THAT INCREASES THE PAIN (Bending, twisting, sitting, coughing, stress, etc) _____

_____

HEALTH HISTORY

HAVE YOU RECEIVED TREATMENT FOR YOUR CURRENT CONDITION? YES NO

IF YES, PLEASE LIST_____

ARE YOU TAKING ANY MEDICATIONS OR SUPPLEMENTS? YES NO

IF YES, PLEASE LIST_____

_____

_____

PLEASE LIST ANY FALLS, INJURIES, OR SURGERIES YOU HAVE WITH DATES _____

_____

_____

_____

HAVE YOU HAD ANY X-RAYS, MRI'S, CT-SCANS, OR OTHER TESTING DONE? YES NO

IF YES, PLEASE EXPLAIN _____

PLEASE LIST ANY ILLNESSES, DISEASES, CONDITIONS, OR CONCERNS YOU HAVE HAD _____

_____

_____

ARE YOU PREGNANT? YES NO DUE DATE_____ OBGYN _____

CIRCLE YOUR EXERCISE LEVEL: NONE OCCASIONAL MODERATE DAILY HEAVY

CIRCLE YOUR WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR ATHLETE

CIRCLE ANY HABITS YOU MAY HAVE: SMOKING ALCOHOL COFFEE/CAFFEINE HIGH STRESS MARIJUANA

FREQUENCY OF EACH _____

DO YOU HAVE, OR HAVE YOU HAD:	CURRENT	PAST	TREATMENT
Cancer	☐	☐	
Stroke	☐	☐	
Heart Disease/Heart Attack	☐	☐	
Epilepsy	☐	☐	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Migraine	☐	☐	

DO YOU HAVE A FAMIY HISTORY OF ANY OF THE ABOVE CONDITIONS? IF SO LIST WHOM: _____

_____

_____

PRIMARY CARE PHYSICIAN _____ PHONE _____

☐ I, _____ certify that I have answered all questions truthfully and to the best of my ability.

_____ _____

Signature Date

9034 E Easter Place #207 Centennial, CO 80112 Phone: 802-379-6895 E-mail: victoria@denverpainandperformance.com
www.denverpainandperformance.com

Dr. Victoria L. Welch, DC, LLC

INFORMED CONSENT

As with all health care professions, CHIROPRACTIC is associated with very rare potential risks in the delivery of treatment. While chiropractic is extremely safe, it is our policy that all patients read and understand fully those possible risks involved with the chiropractic treatment prior to initiating treatment. Please understand that we are highly trained in patient examination and evaluation, allowing us to avoid many of the risks herein.

Stroke is the most serious known complication of chiropractic treatment. It occurs in very rare circumstances after cervical manipulation and is due to and injury to the vertebral artery. Cervical treatment posts a very small risk. The most recent studies indicate that the incidence of stroke is approximately one in every three million cervical adjustments. Practitioners can lower this occurrence even further with proper orthopedic testing and history taking during their examination. Soreness may occur as a side effect after the adjustment and can last for 24-48 hours. This is a normal and accepted response to chiropractic care. If you do feel any abnormal amount of pain, or if you are uncomfortable for a prolonged period of time following treatment, please inform us. Soft tissue injury may result from chiropractic care. On occasion discs, joints, ligaments and tendons can become irritated from an adjustment. Rib injury or fracture is a rare side effect of thoracic spine manipulation. Treatment is provided carefully to avoid such circumstances. Physical therapy modalities may cause rare minor burns to the skin and should be reported to the doctor or staff member if they occur. Other rare sided effects may occur as result of chiropractic care and should be immediately reported to Dr. Victoria L Welch, DC, LLC.

While we make it a goal to provide the best possible treatment for every one of our patients, it is important that patients understand that we cannot promise a cure for every symptom, condition, or disease as a result of treatment in our office. Every attempt will be made to treat your condition to the best of our abilities. If we do not achieve the results we hope for, we will refer you to another provider who we feel can better assist you with your condition. If you have any questions or concerns with the above mentioned material today or at any point during your course of care, please feel free to ask questions. When you have a full understanding of the above mentioned material, and consent to receiving chiropractic care in our office, please print you name, sign and date below.

_____ _____

Print name Signature Date

_____

Witness Signature Date

CONSENT TO TREAT A MINOR

As the parent/guardian of _____, I hereby give my consent for my child to obtain chiropractic care. I understand the risks involved with the chiropractic treatment prior to initiating treatment.

_____ _____

Name of Minor Date of Birth Parent/Guardian Signature Date

_____

Witness Signature Date

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