Sarchenko Chiropractic & Nutrition Services, PC

872 Heritage Park Blvd, 130. Layton UT 84041 (801) 784-7104

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Your Last Name

Gender
◯ Male ◯ Female

Your Social Security Number

Your First Name | **Your Middle Name (Or Initial)** | **Birth Date (MM/DD/YYYY)** | **Height**

Address

Marital Status
◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Weight

City | **State** | **ZIP/Postal Code**

Home Phone | **Cell Phone** | **Spouse's Name** | **Spouse's Birth Date**

E-Mail Address

Child's Name & Age

Emergency Contact | **Phone**

Child's Name & Age

Your Occupation | **Your Employer**

Child's Name & Age

Primary Physician | **Insurance That May help**

Health Savings Account **YES** **NO**

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I certify that to the best of my knowledge I am not pregnant. I will also notify my health care practitioner(s) should I get pregnant.**

Initials _____ **I grant permission to be called/texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. All sales are Final.**

Initials _____ **I may request a copy of the Financial, HIPPA and/or other related policies at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature | Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

CONFIDENTIAL HEALTH INFORMATION

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Name:_____ **Date:**_____

Review of systems Please Circle conditions you are experiencing or had in the past so we will be better able to help you

	Current	Past	Fam
a. **Musculoskeletal System -** Osteoporosis, Arthritis, Neck, Back, Posture, Stiffness, Tension	☐	☐	☐
b. Digestive System – Heartburn, Constipation, Diarrhea, Upset Stomach, Yeast, Crohn's, IBS, Celiac	☐	☐	☐
c. Cardiovascular System - High Blood Pressure, Low Blood Pressure, High Cholesterol, Chest pain	☐	☐	☐
d. Integumentary System - Skin Cancer, Psoriasis, Eczema, Acne, Hair Loss, Rash, Varicose Veins	☐	☐	☐
e. Genitourinary System - Kidney Stones, Infertility, Bedwetting, Prostate issues, PMS Symptoms	☐	☐	☐
f. Constitutional System - Fainting, Low Libido, Poor Appetite, Fatigue, Sudden Weight, Weakness	☐	☐	☐
g. Lymphatic System - Swelling or Pain in Lymph Nodes of Neck, Axillae, Groin & Other Regions	☐	☐	☐
h. Endocrine System - Thyroid, Parathyroid, Adrenals, Pituitary, Hypothalamus, Ovaries, Testis, Cold Feet or Hands, Hot Flashes, Cold Sweats	☐	☐	☐
I. Neurological System - Loss of Smell / Taste, Headache / Migraines, Dizziness, Pins & Needles, Numbness, Buzzing in Ears, Anxiety, Neuropathy, Sleep Issues, Light Bothers eyes, Depression	☐	☐	☐
j. Immune - Weak Immune, Fever or Bacterial Infections, Achy, Chapped Lips	☐	☐	☐

Prior illnesses, operation, injuries or treatments (Please provide dates)**:**_____
_____
_____
_____

Medications/Supplements Currently on (Please list why):_____
_____
_____

List health concerns that are common in your family or may be related to your current health:_____
_____
_____

List any additional health concerns or goals you would like to discuss with the doctor today or at a future visit:_____
_____
_____

Social & Other History (Tell Salt Valley about your health and habits)

	Yes	No	Former		Yes	No
a. Do you drink alcohol?	☐	☐	☐	d. Do you want to improve overall health	☐	☐
b. Do You Smoke?	☐	☐	☐	f. Do you exercise regularly?	☐	☐
c. Do you miss meals?	☐	☐		g. Are you interested in a life changing program now?	☐	☐

NOTES / GOALS: _____

CONTINUE TO NEXT PAGE

PLEASE DO NOT WRITE IN THE BOX BELOW – OFFICE USE ONLY

Measurements

Neck		Hips
Shoulders		Right Bicep
Chest		Right Thigh
Waist	IVR Only – Upper Waist	Right Calf

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EXAM
PATIENT HISTORY

Incident: PI WC Group Cash MC

Insurance: _____

Name:_____ **Date:_____**

1. **What symptoms prompted you to seek care today?**

_____

2. **When did these symptoms start? _____**

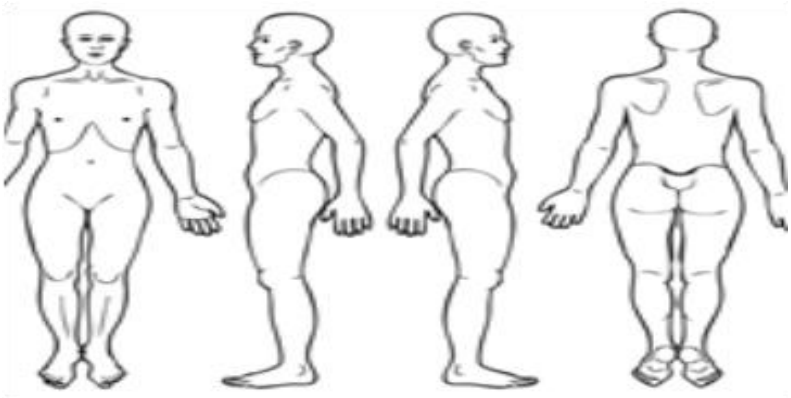
3. How did they start? _____

4. **Intensity** (How extreme are symptoms)
No Symptoms 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 **Worst Symptoms Ever**
(-------- Mild -------)(------- Moderate --------)(------ Severe ------)

5. **Quality of Symptoms**(What does it feel like?)

Achy	Burning	Stiffness	Soreness
Dull	Sharp	Stabbing	Headaches
Numb	Spasm	Shooting	Tingling
Pain & Cramps	Pins & Heavy	Needles	Weakness

Other_____



6. **Duration & Timing** (how often do you feel it?) ◯ Constant ◯ Comes and goes

7. **Worse in the** ◯ Morning ◯ Day ◯ Night

8. **Radiation** (Does the pain radiate, shoot or travel to other spots & where?)

_____

9. **Aggravating or Relieving Factors** (What make it better or worse, what movements or activities, etc.)

What Makes it better? _____ What Makes it worse? _____

10. **Prior Interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Over-the-counter drugs ◯ Ice ◯ Heat ◯ Chiropractic Other _____

11. **What else should Salt Valley know about your current condition?**

_____

12. What are Your **Goals you want us to help you with?**

_____

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INFORMED CONSENT TO TREAT

For all services, including Chiropractic, Weight Loss, Lipo Lights & Nutrition

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent / Guardian:_____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

Rev. 6/9/2021 Dr. Rick