Rise Chiropractic 239 S. French Broad Ave Asheville, NC 28801 828.989.8369

Name: _____ **Date of Birth:** _____ **Age:**_____ **Sex: M F**

Address: _____ **City/State:** _____ **Zip:** _____

Phone: (H) _____ **(W)** _____ **(C)** _____ **SS#** _____

Email: _____

Occupation: _____ **Employer:** _____

Marital Status: ____ **Single** ____ **Married / Partner** ____ **Separated** ____ **Divorced** ____ **Widowed**

Spouse/Partner's Name: _____ **Children's Name/Age:** _____

How did you hear about our office? _____

Have you been to a chiropractor before? Y N **Approximate date of last adjustment:** _____

PRIMARY COMPLAINT: _____

When did it start? _____ **Did it begin:** Gradual Sudden Progressive over time

Please rate the intensity of your symptoms on a scale of 1-10 (10 being the worst pain) _____

Result of a specific incident? Y N **Date of incident:** _____

If yes, please explain: _____

Have you ever had same condition? Y N **If yes, when?** _____

Type of Pain: Sharp Dull Ache Burn Other_____ **Does the Pain Radiate into your:** Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no **How often do you experience these symptoms?** _____

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Please list all previous treatments for this condition.

_____

SECONDARY COMPLAINT: _____

When did it start? _____ **Did it begin:** Gradual Sudden Progressive over time

Please rate the intensity of your symptoms on a scale of 1-10 (10 being the worst pain) _____

Result of a specific incident? Y N **Date of incident:** _____

Type of Pain: Sharp Dull Ache Burn Other_____ **Does the Pain Radiate into your:** Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no **How often do you experience these symptoms?** _____

What makes the symptoms increase? _____ **What relieves the symptoms?**_____

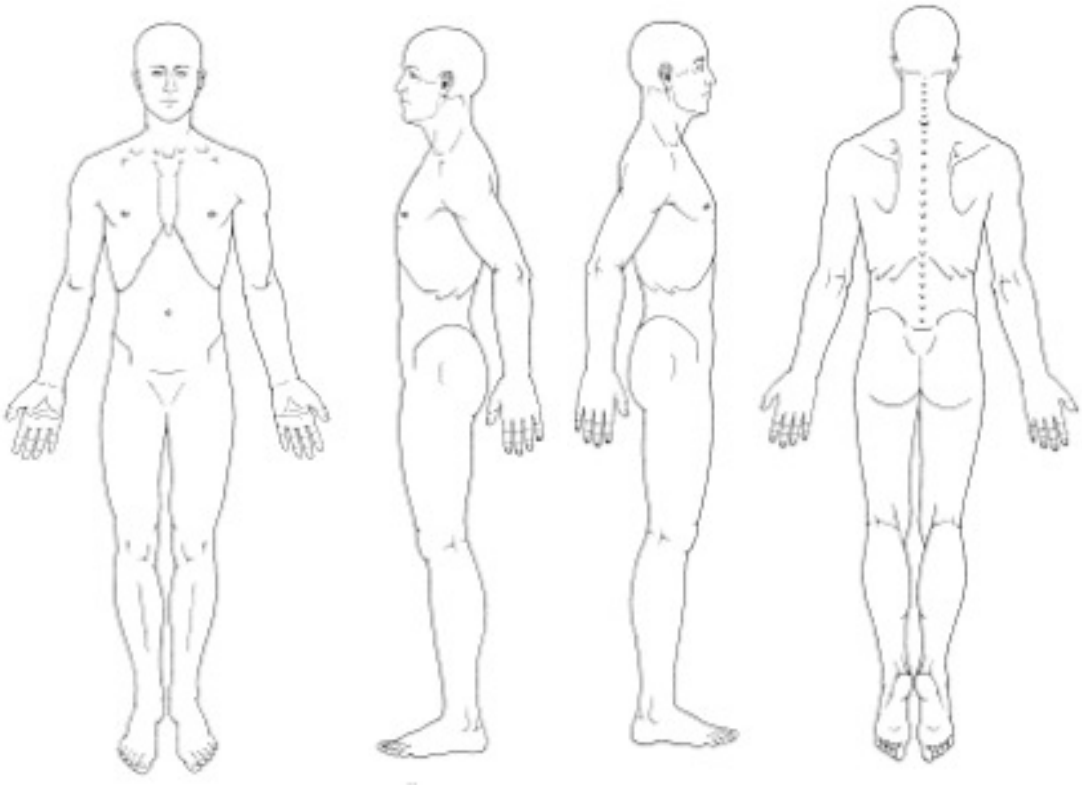
Please list all previous treatments for this condition.

_____

_____ _____

Signature Date

Please mark off the areas of your complaint on the diagram.



FAMILY HEALTH HISTORY

Indicate which family member has/had the following conditions: (Father, Mother, Sister, and Brother)

☐ Diabetes_____ ☐ Heart Disease_____ ☐ High/Low Blood Pressure _____

☐ Cancer _____ ☐ Stroke_____ ☐ Epilepsy _____

☐ Other_____

Please *check* what you currently experience and *circle* what you have had in the past.

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Whooping Cough	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Venereal Disease	☐Rheumatoid Arthritis	☐ Colitis	☐ Other	

_____ _____

Signature Date

TRAUMA HISTORY

- Jobs of all types have inherent movements that may be repetitive in nature or require lifting, excessive sitting, computer work, etc. Please list any occupational stress you have or have had and note any/all traumas, whether reported or not.

_____
_____

- Sports and recreational activities can place stress on anyone's spine because they are usually one sided movements. Please list any/all sports or recreational activities you currently or have ever participated in, along with any injuries from them.

_____
_____

- Have you ever been struck unconscious? ☐ YES ☐ NO If yes, list date of incident and how it happened.

_____
_____

- Have you ever been hospitalized? ☐ YES ☐ NO If yes, please explain.

_____
_____

- Please list any accident small or large that may have occurred around your house i.e. falls off ladders, slips etc.

_____
_____

- Have you ever been in an auto accident? ☐ YES ☐ NO If yes, please explain.

_____
_____

- Have you ever broken bones? ☐ YES ☐ NO If yes, please explain.

_____
_____

- Have you had surgery? ☐ YES ☐ NO If yes, please explain.

_____
_____

_____ _____
Signature Date

Rise Chiropractic
Dr. Steven Cassese
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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

When a person seeks chiropractic care it is essential that both they and the chiropractor are both working towards the same goals. It is important that the patient understands and accepts the objective of Rise Chiropractic. In this way, there will be no confusion, misunderstanding or false expectations.

Vertebral Subluxations are misalignments of the spinal bones that interfere with the normal physiology of the nerve system. This results in abnormal transmission of neurological impulses, which in time may lead to symptoms, sickness and decreased health potential. Chiropractic **adjustments** remove this interference to the nerve system **caused by subluxations** of the spine. With proper nerve supply restored, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. For some, the repair and maintenance is complete; in others, only partial.

We do not offer to **diagnose or treat disease.** We do not attack or suppress symptoms. If, during care, you become concerned about your symptoms or your condition, we suggest that you seek the help of a symptom care professional. Our only goal is to remove interference to the body's innate health potential caused by **subluxations,** allowing the body to achieve a higher level of health.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Steven Cassese and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Cassese and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____	_____	_____
Print Patient's Name	Patient Signature	Date
_____	_____	_____
Print Name of Representative	Representative Signature	Date

How We Protect Your Private Health Information

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Rise Chiropractic** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at this practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

This office will not share or sell any of your information including psychographic or demographic, to third party retailers.

I have the right to revoke this consent, in writing, except to the extent that Rise Chiropractic or **Dr. Steven Cassese** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name	Patient Signature	Date
Witness Printed Name	Witness Signature	Date

PLEASE GIVE 24 HOURS NOTICE WHEN CANCELING AN APPOINTMENT. _____
Initial

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