Dr. Scott R. Cramer, D.C., F.A.C.O., Dipl. Med. Ac.
1485 Garden of the Gods Rd., Suite 156, Colorado Springs., CO 80907 (719) 433-0750

Consent Form for Chiropractic, Acupuncture and/or Cold Laser Therapy

Chiropractic focuses on the nervous system and the spinal cord. During chiropractic treatment, the Doctor will use his/her hands or a mechanical device in order to align spinal segments to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Many treatments involve adjusting procedures; some do not.

Some patients may notice stiffness or soreness for a short time after treatment, especially after the very first time you are treated. This is a normal reaction for a spine which has been out of alignment for a period of time. as with any health care procedure, complications are possible following chiropractic treatment. Risks have been described as extremely rare, far less than complications seen from taking a single baby aspirin. Nevertheless, a patient could incur muscle spasms, stiffness, and/or soreness as the body responds to corrective treatment. Other risks may include fracture, vascular compromise such as damage to vessels leading to stroke, and nerve damage. Screening procedures are used to avoid bone fracture, especially in older patients, and the risks of any "serious" side effects of an adjustive procedure are somewhere in the one in a million to one in 20 million range. Chiropractic is very safe and effective; therefore it is important to report any changes or concerns to the Doctor.

Only disposable needles are used for acupuncture; OSHA guidelines, as well as those promulgated by the Colorado Department of Health are adhered to. Occasionally, a condition may get worse before it gets better. If you do not show improvement, or your condition worsens, this could be a sign of a serious condition. Referral to other health care providers may be utilized.

I, ______________________________, understand the risks, hazards, and potential dangers involved in treatment by means of chiropractic, acupuncture and/or laser. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made. I understand that it usually requires a series of chiropractic, acupuncture and/or laser treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure, and authorizes this procedure should I require it for my condition. I agree to hold Dr. Cramer harmless, and indemnify him from any claim that may arise out of this, or any treatment. If I am a minor, my parent or acting guardian has read and understands the above items, and his/her signature attests to this fact.

______________________________ ______________ ______________
Patient/Authorized Representative Signature Relationship to Patient Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

______________________________ ______________
Practitioner Signature Date

Dr. Scott Cramer, D.C., F.A.C.O., 1485 Garden of the Gods Rd., # 156, Colorado Springs, CO 80907

Name: ______________________ Email: ______________________

SSN: ______________________ Maiden or Former Name: ______________________

Sex: M F Date of Birth: ______________ Marital Status: M S D Sep W

Home Address: ____

City: ______________________ State: __________ Zip: __________

Employer: ______________________ Occupation: ______________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Referred By: ____

Emergency Contact Name: ______________________ Phone: ______________

Insurance Carrier: ____

When was the onset of the condition for which you are seeking treatment? ______________________

***Please Answer the following questions regarding your health care experiences*:**

Chiropractic:

I have had Chiropractic Care in the Past Y N

If yes, I am/was pleased with the results Y N

I understand the meaning of **SUBLUXATION** Y N

Had Covid 19, recovered? Y N

Vaccinated against Covid 19? Y N

Which Vaccine? Pfizer Moderna Johnson & Johnson **Booster (s) Y**

Acupuncture:

I have had Acupuncture in the past Y N

If yes, I was pleased with the results Y N

I understand the meaning of **MERIDIAN** Y N

Cold LASER:

I have had Low Level Light Therapy in the past Y N

I would like to try the Cold Lasers if they can help Y N

Nutrition:

I have a clear understanding of how herbs and supplements support cellular function Y N

I am interested in receiving metabolic counseling for my signs and symptoms Y N

Who is responsible for payment? Self / Other- Name: ______________________ Relationship ______________

_______Self pay (Cash, Check, Debit, Credit, HSA, etc.) _______ Personal Injury (Auto Accident) ________Workers' Comp

Acknowledgement of Notice of Privacy Practices: We protect your personal health information. Our office may need to contact you regarding office matters. By signing below, you agree to be contacted by phone, email, or regular mail. Messages may be left either by voicemail, or with the person answering your phone. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated 9/23/2013, this office is obliged to supply you with a copy of the office privacy policies upon request. This document outlines the use and limitations of the disclosure of your personal information, and your rights as a patient. By signing below, you acknowledge that you have been offered a copy of this document.

Acknowledgement of Assignment of Benefits: By signing below, you have acknowledged that you are fully responsible for all services rendered in this office, and that you may be required to pay for some or all of the fees charged to your account. By signing below, you hereby authorize benefits to be paid directly to this office/provider by any 3rd party payer, Insurance Company, Attorney, etc. By signing below, you agree that this a non-rescindable agreement, and failure to fulfill this obligation, will be considered a breach of contract between you and this office. By signing below, you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS and ACCEPTANCE form, and you certify that all of the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient: ______________ Signature of Parent/Guardian: ______________ Date: __________

(It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged)

COMPLAINT INFORMATION

Date: ___________ **Patient No:** __________

History of Current Condition

Major Complaint: ____

Secondary Complaint: ____

When and How this began? ____

____

____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _______________

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _________________________

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ________________________

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ________________________

Which daily activities are being affected? (*Describe*) ________________________

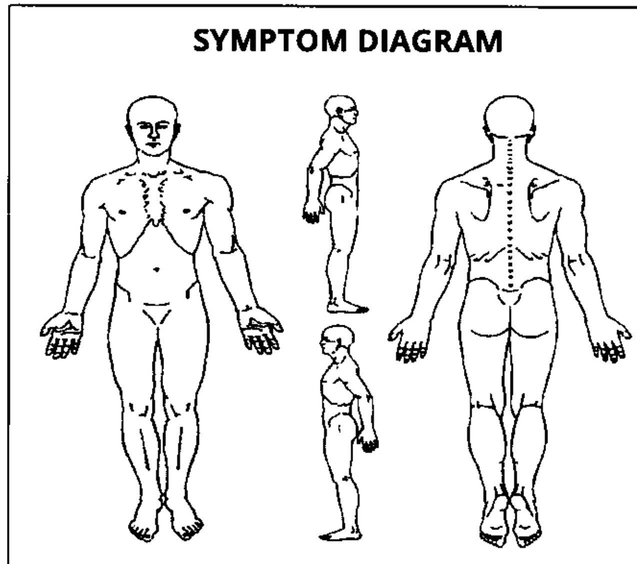
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _______________ Where: ____________________

Other Diagnostic Testing? X-rays / MRI / CT / Other: __________________ Where: ____________________

Pain/Complaint Diagram

Please Circle all areas where you are experiencing pain or discomfort.
check what type of pain you are experiencing in those areas.



What type of pain are you experiencing?

- ___General Pain
- ___Numbness
- ___Spasm
- ___Tender
- ___Hypoesthesia

Patient Signature: ________________________________ ***Physician's Initials:*** __________

REVIEW OF SYSTEMS

Patient Name: (First MI Last) ______________________________ **Patient No:** ____________

Review of Systems

Zone 1 Glandular System:
- ☐ Memory Loss
- ☐ Sleep
- ☐ Skin
- ☐ Hair
- ☐ Menstrual
- ☐ Thyroid/Energy
- ☐ Adrenals
- ☐ Anxiety/Depression
- ☐ ED/Fertility
- ☐ Hot Tempered
- ☐ Unable to Concentrate
- ☐ Low Immunity

Zone 2 Eliminative System:
- ☐ Sinuses
- ☐ Throat
- ☐ Kidneys
- ☐ Bladder
- ☐ Intestines/Colon
- ☐ Nasal Passages
- ☐ Lungs
- ☐ Bronchitis/Pneumonia
- ☐ Lymphatic
- ☐ Bloating/Toxins

Zone 3 Nervous System:
- ☐ Eyes
- ☐ Balance/Dizziness
- ☐ Poor Sleep
- ☐ Solar Plexus
- ☐ Unable to Relax
- ☐ Nervousness
- ☐ Ears
- ☐ Tingling in Extremities
- ☐ Allergies/Food Issues
- ☐ Digestion
- ☐ Tensions
- ☐ Hormone Imbalances

Zone 4 Digestive System:
- ☐ Appetite
- ☐ Acid Reflux
- ☐ Liver
- ☐ Stomach
- ☐ Intestines
- ☐ Digestion
- ☐ Taste
- ☐ Heartburn
- ☐ Gallbladder
- ☐ Pancreas
- ☐ Weight Gain
- ☐ Elimination

Zone 5 Muscular System:
- ☐ Neck
- ☐ Arms/Hands
- ☐ Middle Back
- ☐ Legs/Feet
- ☐ Abdomen
- ☐ Disc Problems
- ☐ Shoulders
- ☐ Upper Back
- ☐ Lower Back
- ☐ Chest
- ☐ Weakness
- ☐ Muscle/Joint Pain

Zone 6 Circulatory/Lymphatic System:
- ☐ Thyroid
- ☐ Blood Pressure
- ☐ Heart Problems
- ☐ Headaches/Migraines
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Poor Circulation

Health History

Medications and Supplements:

Allergies to Medications: ☐ NONE

Name	Reaction

Current Medications & Supplements: ☐ NONE

Name	Dosage

Past Health History:

Surgeries: ☐ NONE

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐ NONE

Date	Describe

Family Health History: ☐ NONE

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐ Every Day ☐ Some Days ☐ Former ☐Never

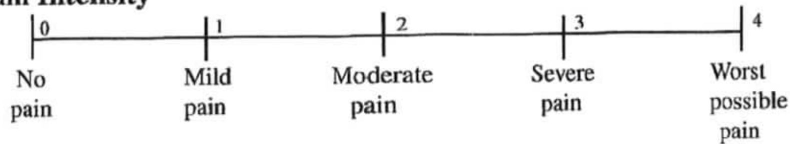
Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Functional Rating Index

For use with **Neck and/or Back Problems** only.

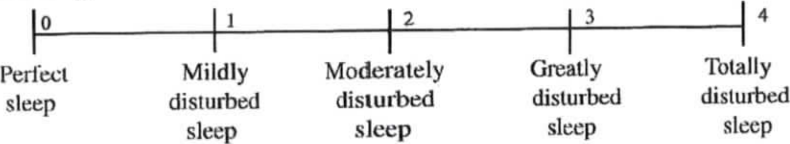
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



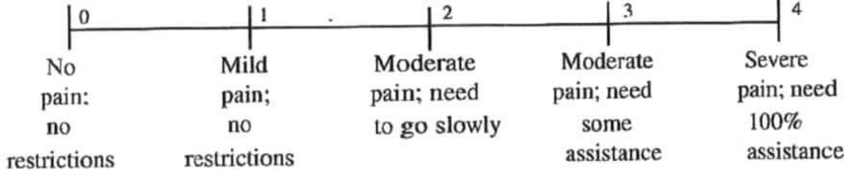
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



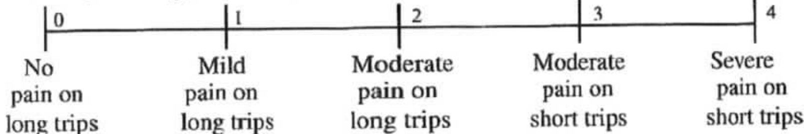
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



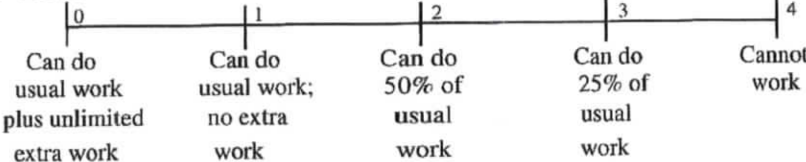
0	1	2	3	4
No pain: no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



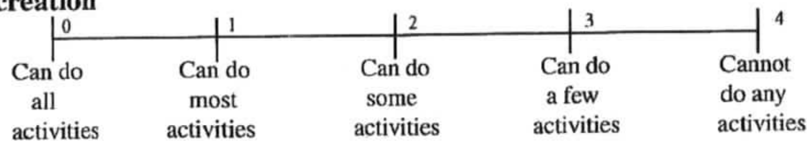
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



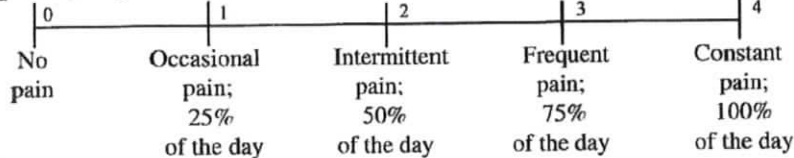
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



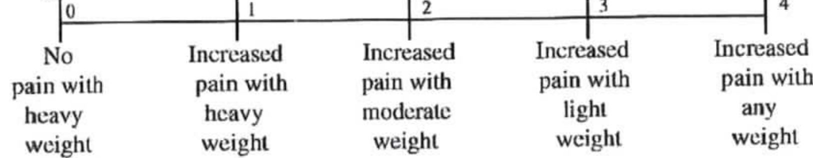
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



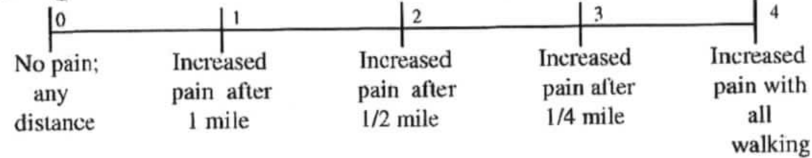
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



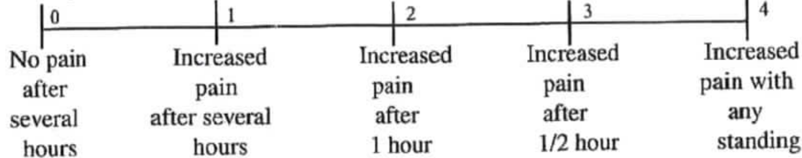
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score ________

Name ________________________
PRINTED

X ________________________
Signature

____
Date

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