

Luke Boyer, DC

Chiropractic Physician

Complementary Sports Medicine

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_ Gender (circle): M F Marital status \_\_\_\_\_\_\_\_ No. of children \_\_\_\_

Name of partner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever seen a Chiropractor? No Yes (Who?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

Health plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Accident Information**

Is this consultation due to an accident? □ Yes □ No If so what was the date of the accident: \_\_\_\_\_\_\_\_ Type of accident: □ Auto □ Work □ Home □ Other

Did you file an accident report or police report? □ Yes □ No

**Chief complaint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you seen other health care provider(s) for this condition? No Yes (explain): \_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you tried over the counter medication for this condition? No Yes (explain): \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any diagnostic images taken for this complaint? No Yes (circle below):

X-ray CT scan MRI Ultrasound Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your condition affected your daily activities? No Yes (explain): \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does you condition affect your sleep? No Yes (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this problem getting worse? \_\_\_\_\_\_Constant? \_\_\_\_\_Worse in morning? \_\_\_\_\_\_Evening?\_\_\_

Is this interfering with work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your concerns about this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List other problems you have now\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List past operations and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized other than surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any mental or emotional disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any other injury in the past two years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking medications? \_\_\_\_\_\_\_\_\_ Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking nutritional supplements? \_\_\_\_\_\_\_\_\_ Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any foods, drugs, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dental problems? \_\_\_\_\_\_\_\_\_\_ Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear arch supports? \_\_\_\_\_\_\_\_\_ Heel lifts? \_\_\_\_\_\_\_ Special shoes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any significant head injuries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last physical exam? \_\_\_\_\_\_\_\_\_ Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood test? \_\_\_\_

Habits (describe with amounts):

Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drugs not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your present exercise habits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the main health problems in your family:

Relation: Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please list the name and number of a friend or relative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the space provided, please enter “C” if you currently have or “P” if you have had this problem

**General**  **EENT**  **Cardiovascular**

\_\_\_\_\_\_\_ Excess weight gain/loss \_\_\_\_\_\_\_ Poor vision \_\_\_\_\_\_\_ Irregular heart beat

\_\_\_\_\_\_\_ Bleeding problems \_\_\_\_\_\_\_ Loss of vision \_\_\_\_\_\_\_ Pain over heart

\_\_\_\_\_\_\_ Anemia \_\_\_\_\_\_\_ Eye pain \_\_\_\_\_\_\_ High/low blood pressure

\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_ Deafness \_\_\_\_\_\_\_ Previous heart trouble

\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_ Nosebleeds \_\_\_\_\_\_\_ Myocardial infarction

\_\_\_\_\_\_\_ Thyroid disease \_\_\_\_\_\_\_ Sinus problems \_\_\_\_\_\_\_ Ankle swelling

\_\_\_\_\_\_\_ Alcoholism \_\_\_\_\_\_\_ Hoarseness \_\_\_\_\_\_\_ Varicose veins

\_\_\_\_\_\_\_ Drug abuse \_\_\_\_\_\_\_ Tonsillectomy \_\_\_\_\_\_\_ Rheumatic fever

\_\_\_\_\_\_\_ HIV risk factor \_\_\_\_\_\_\_ Colds/flu \_\_\_\_\_\_\_ Poor circulation

\_\_\_\_\_\_\_ Chills \_\_\_\_\_\_\_ Ear problems \_\_\_\_\_\_\_ Rapid/slow pulse

\_\_\_\_\_\_\_ Fainting \_\_\_\_\_\_\_ Sore throats **Neurologic**

\_\_\_\_\_ Fever **Respiratory** \_\_\_\_\_ Weakness

\_\_\_\_\_\_\_ Insomnia \_\_\_\_\_\_\_ Difficulty breathing\_\_\_\_\_\_\_ Twitching

\_\_\_\_\_\_\_ Nervousness \_\_\_\_\_\_\_ Chronic cough \_\_\_\_\_\_\_ Tremors

\_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_ Spitting up blood \_\_\_\_\_\_\_ Headaches

\_\_\_\_\_\_\_ Sweats \_\_\_\_\_\_\_ Spitting up phlegm \_\_\_\_\_\_\_ Dizziness/Vertigo

**Genitourinary** \_\_\_\_\_\_ Wheezing/Asthma \_\_\_\_\_\_\_ Epilepsy

\_\_\_\_\_\_\_ Frequent urination\_\_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_\_ Mental disorder

\_\_\_\_\_\_\_ Painful urination \_\_\_\_\_\_\_ Tuberculosis \_\_\_\_\_\_\_ Partial or complete paralysis

\_\_\_\_\_\_\_ Blood in urine **Other** **Musculoskeletal**

\_\_\_\_\_\_ Kidney disease \_\_\_\_\_\_\_ Tropical infection \_\_\_\_\_\_\_ Arthritis

\_\_\_\_\_\_\_ Urinary infection \_\_\_\_\_\_\_ Parasitic infection \_\_\_\_\_\_\_ Foot trouble

\_\_\_\_\_\_\_ Breast lump or pain **Gastrointestinal** \_\_\_\_\_\_ Hernia

\_\_\_\_\_\_\_ Venereal disease \_\_\_\_\_\_\_ Appendicitis \_\_\_\_\_\_\_ Low back pain

\_\_\_\_\_\_\_ Sexual difficulty \_\_\_\_\_\_\_ Poor digestion \_\_\_\_\_\_\_ Neck pain

\_\_\_\_\_\_\_ Prostate problems \_\_\_\_\_\_\_ Difficulty swallowing \_\_\_\_\_\_\_ Poor posture

**Skin** \_\_\_\_\_\_\_ Vomiting blood \_\_\_\_\_\_\_ Sciatica

\_\_\_\_\_\_\_ Itching \_\_\_\_\_\_\_ Pain over abdomen **Pain/Numbness in:**

\_\_\_\_\_\_ Bruises easily \_\_\_\_\_\_\_ Ulcer \_\_\_\_\_\_\_ Shoulders

\_\_\_\_\_\_\_ Changes in mole(s) \_\_\_\_\_\_\_ Bloody stool \_\_\_\_\_\_\_ Arms

\_\_\_\_\_\_\_ Skin cancer \_\_\_\_\_\_\_ Liver problems \_\_\_\_\_\_\_ Elbows

\_\_\_\_\_\_\_ Boils \_\_\_\_\_\_\_ Gallbladder problems \_\_\_\_\_\_\_ Wrist/Hand

\_\_\_\_\_\_\_ Dryness \_\_\_\_\_\_\_ Jaundice \_\_\_\_\_\_\_ Hips

\_\_\_\_\_\_\_ Loss of bowel control \_\_\_\_\_\_\_ Legs

\_\_\_\_\_\_\_ Diarrhea \_\_\_\_\_\_\_ Knees

\_\_\_\_\_\_\_ Constipation \_\_\_\_\_\_\_ Feet

For women only: \_\_\_\_\_\_\_ Menstrual problems \_\_\_\_\_\_\_ Hot flashes

Date of last period: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Irregular cycle \_\_\_\_\_\_\_ Menopausal symptoms

**Informed consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned have voluntarily requested that Dr. Luke Boyer assist me in the management of my health concerns. I understand that Dr. Boyer is a chiropractor and that his services are not to be construed or serve as a substitute for standard medical care. Dr. Boyer recommends that I undergo regular routine medical check-ups by medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Exercise and nutritional counseling may also be used.

Although spinal manipulation/adjustment is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments. There also may be occasional slight bruising and tenderness following certain manual therapy techniques.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Boyer if you experience these symptoms.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormally is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

A thorough health history and tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Treatment results:** I also understand that there are beneficial effects associated with these treatments including decreased pain, improved mobility and function, and reduced muscle spasms. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor’s choosing.

**Alternative Treatments Available:** Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medications can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of great value, but are not corrective of injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthesia, and prolonged recovery.

**Non-treatment:**  I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I have read and or have had read to me the above explanation of chiropractic treatment. Any questions 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. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_