



# ***Bucks Sports Chiropractic***

**Dr. Derek Gearhart**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact (name and phone): \_\_\_\_\_

How you found me/referral: \_\_\_\_\_

Insurance:

Insurance Company: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Primary Insured (Full Name): \_\_\_\_\_

Relationship to Primary Insured (please circle):      Spouse      Child      Self

Describe your symptoms and how they began:

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When did your Symptoms begin (give a specific date): \_\_\_\_\_

Describe the type of pain you are feeling (please circle all that apply):

Dull	Ache	Sharp	Shooting	Numb	Piercing
Burning	Stabbing	Throbbing	Pins/Needles	Stiff	Spasm



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What is your pain range on a scale of 0-10 with "0" being no pain and "10" being the worst?

0    1    2    3    4    5    6    7    8    9    10

What Helps Your Symptoms (please circle all that apply):

Rest	Ice	Heat(warm shower)	Ibuprofen(Advil)	Tylenol	Stretching
Exercise	Yoga	Rest	Prescription Pain Killers	Sleep	
Chiropractic	Massage	Active Release	Hawk Grips	Other	

Do your symptoms prevent you from doing what you want or affect your daily routine?                      Yes/No

What are you unable to do:

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How often are Your Symptoms Present (please circle):

25% of the time                      50% of the time                      75% of the time                      100% constant

When do your symptoms affect you the most (please circle all that apply):

Morning	Afternoon	Evening	Bedtime	Before Exercise
After Exercise	During Exercise	Sitting	Driving	Standing
Running	Walking	Bending	Reaching	Squatting

Are you currently being treated by another physician?    Yes/No    If Yes, please list: \_\_\_\_\_

Please list any and all medication and supplements you are taking:

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## **Dr. Derek Gearhart**

Please list any and all significant family history (cancer, heart disease, auto-immune, etc):

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Please list your injury history including MRI's, X-rays & Surgeries:

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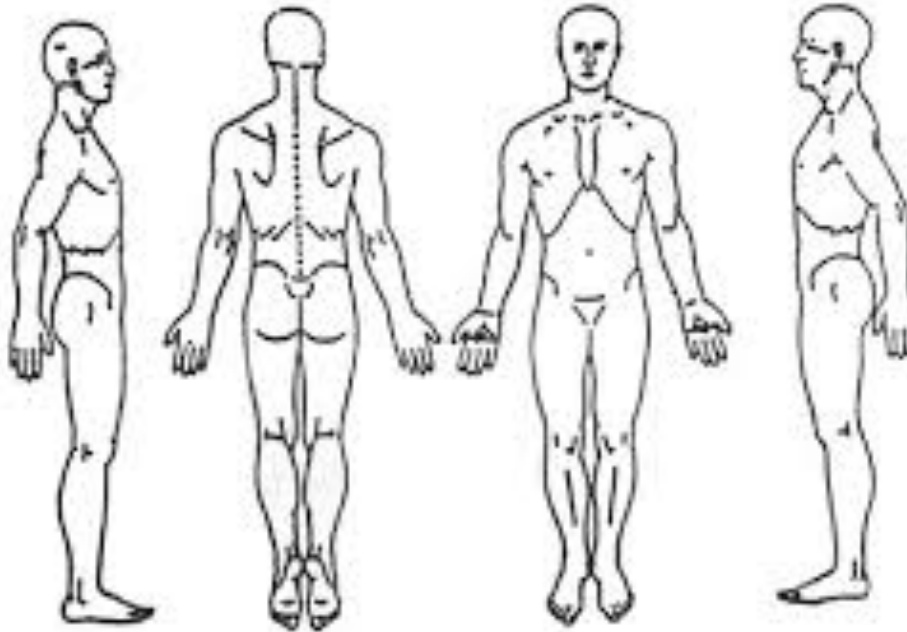
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Have you had blood work in the last year? Yes/No

Have you had a physical in the last year? Yes/No

Please mark where your pain is located:





## ***Informed Consent to Chiropractic Treatment***

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

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Printed Name

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Signature

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Date



# ***Bucks Sports Chiropractic***

**Dr. Derek Gearhart**

I, \_\_\_\_\_, have reviewed the HIPPA policies and procedures pamphlet presented at my initial evaluation by Bucks Sports Chiropractic and Dr. Derek Gearhart. I understand my rights as a patient, and I, \_\_\_\_\_, was presented with documentation detailing what those rights are in accordance with HIPPA policy.

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Signature

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Date