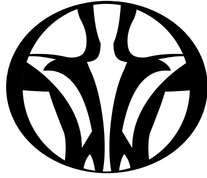

MUSCLE WORKS
CHIROPRACTIC AND MUSCLE ACTIVATION

Patient Information

Date: ________________
Name: ________________
Address: ________________
City: __________ State: ______ Zip: ______
Date of Birth: __________ Gender: ______
Occupation: ________________
Employer: ________________
Primary Care Physician (PCP): ________________
Can we inform PCP you're under our care?: ______
How did you hear of us?: ________________

Contact Information

Home Phone: ________________
Cell Phone: ________________
Work Phone: ________________ Ext: ______
Email: ________________@__________
Preferred Contact: Home Cell Work Email Text

Emergency Contact

Name: ________________
Relationship: ________________
Address: ________________
City: __________ State: ______ Zip: ______
Same as Patient? Yes No
Phone Number: ________________

Condition #1

What condition are you here for today?
____
____
When did it begin? ________________
How did it begin? ________________
Is it: Improving Worsening Staying the Same
Is it: Mild Moderate Severe
What worsens it: General Activity Bending Lifting Walking Sports Standing Sitting Laying down
Other: ________________
What makes it better: Rest General Activity Ice Heating Pad Massage OTC Meds Chiropractic
Other: ________________
Is it worse in the: AM PM Steady Random
Is the symptom: Dull and Achy Tight and Stiff Sharp and Stabbing Numb and Tingly Shooting Burning Cramping

Condition #2

What condition are you here for today?
____
____
When did it begin? ________________
How did it begin? ________________
Is it: Improving Worsening Staying the Same
Is it: Mild Moderate Severe
What worsens it: General Activity Bending Lifting Walking Sports Standing Sitting Laying down
Other: ________________
What makes it better: Rest General Activity Ice Heating Pad Massage OTC Meds Chiropractic
Other: ________________
Is it worse in the: AM PM Steady Random
Is the symptom: Dull and Achy Tight and Stiff Sharp and Stabbing Numb and Tingly Shooting Burning Cramping

610 W Hubbard #114, Coeur d’Alene ID 83814
Tel: (208) 660-2480 I Email: info@activemuscleworks.com

Dietary Habits

Do you smoke? Yes No Amount: ____________
Drink alcohol? Yes No Amount: ____________
Drink Soda? Yes No Amount: ____________
Drink Coffee? Yes No Amount: ____________
Water? Yes No Amount: ____________
Other: ______________________________________
____

Exercise Habits

Frequency of exercise ________________________
Duration of exercise __________________________
Type of exercise _____________________________
Activities of Interest: Golf Running Swimming Cycling CrossFit Hiking Walking Weightlifting Baseball Basketball Soccer Football Dancing
Other ____

Treatment Goals

List your short term and long term goals of treatment?
____
____
____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including Clinical Kinesiology (Muscle Activation), FAKTR (Fascia Scraping), and other physical therapy modalities on me (or on the patient named below, for whom i'm 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 the Physician at Muscle Works 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. Brent Hirschi and/or with other office or clinic 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 procedures 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 conditions(s) and for any conditions(s) for which I seek treatment at this facility.

Email policy - your email is used to confirm appointments both when they are scheduled and the day prior to appointment date. Email notices will also be sent from our practice from time to time to inform our patients about different specials, closure dates, health related information and other news. Its our goal not to flood your email with more useless info. If you wish to not receive these emails please use the unsubscribe link at the bottom of your email.

CANCELATION POLICY - Patient must notify Dr. Brent Hirschi via phone message or email 24 hours prior to scheduled appointment of any required changes for appointment date and or times. A $35 charge will be charged to patient for each missed scheduled appointment. ______________(Initial)

____
Print Patient's Name

____
Print Name of Patient Representative (patient under 18)

____
Signature of Patient

____
Signature of Representative

____________/____________/____________
Date

____________/____________/____________
Date