CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Decompression New Patient Intake Form

Name: _____ **Date of Birth:** ___/___/___ Today's Date: ___/___/___

Reason for Visit: _____

When did your symptoms begin? _____

What other treatment have you utilized?_____

Are your symptoms: Getting Better No Change Getting worse

What makes it better: Rest Ice/heat movement Medication Other: _____

What makes it worse: Rest Activity Lifting Walking Sitting Other: _____

Describe your pain: Sharp Dull Achy Stiff Tight Shooting Stabbing Other: _____

Previous Health History:

Have you had any images taken: Yes No If Yes: MRI Xray CT Scan If so, date: _____

Have you had any surgeries: Yes No Procedure, date: _____

_____

Are you currently taking any medications: Yes No If Yes: _____

_____

Are you Pregnant: Yes No

All medical procedures involve risk/side effects. The most common risks/side effects associated with Spinal Decompression are soreness, muscle spasms, and increased pain. Most often, when experienced, the side effect is temporary. The benefits of Spinal Decompression include: pain relief, improved function, reduced disability, intradiscal healing. If you understand the above and give consent to proceed with treatment, please sign and date below.

Signed: _____ Date: _____

Office Use: