DALY CHIROPRACTIC AND WELLNESS

INTRAMUSCULAR AND JOINT INJECTION CONSENT FORM

Patient Information

Last Name		First Name		Today's Date
Home Address		City	State	Zip

Home Phone	Work Phone	Cell Phone	Email Address	
Permission to Leave Messages ☐ YES ☐ NO	Gender	Date of Birth	Age	Martial Status

Occupation	Employer	
Emergency Medical Contact	Phone	Relationship to Patient
Primary Physician Name	Phone	How did you hear about us?

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1.	4.
2.	5.
3.	6.

USUAL HEALTH: ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR** **HEIGHT:**__________ **WEIGHT:**__________ **BP:**________

Do you use any of the following MEDICATIONS more than just occassionally? (**YES** or **NO**)

	Pain Relievers		Birth Control (pills, patch, implant, IUD)		Steroids (inhalers, creams, oral)		Blood Thinners (coumadin, warfarin, heparin)
	Tranquilizers		Thyroid Medication		Nasal Decongestants		Diuertics
	Benzodiazepines		Hormones		Antacids		Appetite Suppressants
	Sleeping Pills		Stimulants		Laxatives		

List any prescription or over-the-counter **MEDICATIONS** and **SUPPLEMENTS** you take regularly.

Name	Dose	Reason	Start Date	Side Effects

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any times.

_______ **INITIAL HERE TO CONFIRM**

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Patient: ______________________________ Date: ______________

R ☐ L ☐ **Splenius Cervicis**	R ☐ L ☐ **Gluteus Medius**
R ☐ L ☐ **Levator Scapulae**	R ☐ L ☐ **Gluteus Maximus**
R ☐ L ☐ **Supraspinatus**	R ☐ L ☐ **Tensor Fasciae Latae**
R ☐ L ☐ **Longissimus Thoracis**	R ☐ L ☐ **Extensor Digitorum**
R ☐ L ☐ **Latissimus Dorsi**	R ☐ L ☐ **Extensor Digitorum Brevis**
R ☐ L ☐ **Deltoid**	R ☐ L ☐ **Quadriceps**
R ☐ L ☐ **Anterior Tibialis**	
OTHER MUSCLE:	
R ☐ L ☐ **Spine Cervical**	R ☐ L ☐ **Spine Thoracic**
R ☐ L ☐ **Spine Lumbar**	R ☐ L ☐ **Spine Sacral**
R ☐ L ☐ **Shoulder**	R ☐ L ☐ **Elbow/ Wrist**
R ☐ L ☐ **Hip**	R ☐ L ☐ **Knee / Ankle**
OTHER JOINT:	

In conjunction with the injection procedure of location(s) outlined above, I understand the following:

a. **Nature and purpose of procedure:** Injection of small muscles with local anesthetic (1% OR 2% Lidocaine), 25% Dextrose, B-12, Ultra Lipoburn, vitamins, amino acids, minerals, ozone, peptides, or Traumeel (a natural anti-inflammatory medicine) to reduce inflammation and relieve pain.

b. **Material risks of procedure:** allergic reaction, bruising, infection, scars, bleeding, dizziness and in rare circumstances, possible collapse of lung, cardiovascular and/or cerebral problems

c. **Likelihood of success:** ☐ Good ☐ Fair ☐ Poor ☐ Unknown

d. **Practical alternatives to procedure:** ☐ Modalities ☐ Therapy

e. **Prognosis if procedure rejected:** ☐ Good ☐ Unknown

f. **I have an allergy to lidocaine or sulfa drugs:** ☐ YES or ☐ NO

If yes, please explain: ______________________________

PATIENT CONSENT: I intend this consent form to cover the entire course of treatment for my current condition. The procedure identified above has been explained to me and all my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure as ordered by the provider indicated below.

____

Patient's Name | Patient's Signature | Date

____

Physician's Name | Physician's Signature | Date