

# ANIMAL PATIENT



# CASE HISTORY

## PERSONAL INFORMATION:

Animal's Name \_\_\_\_\_ Owner's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Preferred Phone Number (H,C,W) \_\_\_\_\_ Alt Phone (H,C,W) \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: F M Spay/Neutered: Y N  
 Breed: \_\_\_\_\_ Weight \_\_\_\_\_ lbs  
 Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

## HEALTH INFORMATION:

Main reason for today's visit \_\_\_\_\_  
 Please list any other concerns in order of importance \_\_\_\_\_  
 \_\_\_\_\_  
 When did this main condition start? \_\_\_\_\_ How did this condition begin? \_\_\_\_\_  
 Had this or similar conditions previously? \_\_\_\_\_  
 What percent of the day is this condition evident? \_\_\_\_\_  
 Is this condition changing? Getting better \_\_\_\_\_ Getting Worse \_\_\_\_\_ Not Changing \_\_\_\_\_  
 How severe is this condition: None 1 2 3 4 5 6 7 8 9 10 Unbearable  
 What makes condition worse? \_\_\_\_\_  
 What makes condition better? \_\_\_\_\_  
 What treatment has been provided for this condition? \_\_\_\_\_  
 Has been to a chiropractor before? Who? When? \_\_\_\_\_  
 Name and location of family veterinarian \_\_\_\_\_  
 List surgical operations/serious illnesses, medical conditions, and years \_\_\_\_\_  
 \_\_\_\_\_  
 Has had any other personal injury or accident?  Past year  Past 5 years  Over 5 years  
 Describe: \_\_\_\_\_  
 Medications (prescription and over-the-counter), nutritional/herbal supplements you currently take \_\_\_\_\_  
 \_\_\_\_\_  
 Please list family members in house human and animals \_\_\_\_\_  
 \_\_\_\_\_  
 Diet \_\_\_\_\_  
 Activity Yes \_\_\_\_ No \_\_\_\_ If so, what type and how often \_\_\_\_\_  
 Anything else to know? \_\_\_\_\_



**PAYMENT INFORMATION:**

Payment for appointment is due on the day of service. We accept cash, checks, and credit/debit cards.

**RELEASE OF MEDICAL INFORMATION:**

I authorize the release of all health information that is relevant to my primary veterinarian, which may be involved with my animal's care. I understand that this authorization is in effect for the duration of treatment and or until I choose to revoke it in writing to: St. Croix Chiropractic and Wellness, P.O Box 883 St Croix Falls, WI 54024

**INFORMATION ABOUT POSSIBLE RISKS OF TREATMENT:**

You have the right, to be informed about the condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to have your animal undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is required by law, and is simply an effort to make you better informed so you may give or withhold your consent to the procedure. You have the right to refuse treatment for your animal at any point, before or during the procedure.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include bruising, soreness, muscle or ligament strain, dislocations, fractures, or disk injuries. These are extremely rare occurrences.

**CONSENT FOR TREATMENT:**

I authorize Dr. Joy K. Zasadny, DC, VSMT to perform an examination, diagnostic testing and treatment on my animal as deemed necessary. I certify that no guarantee or assurance has been made to the results that may be obtained. I certify that the information I have provided is correct to the best of my knowledge, and I will not hold Dr. Joy responsible for any errors or omissions that may have been made in the completion of this form. Having carefully read the above, I hereby give my informed consent to have chiropractic care administered to my animal.

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Signature of Owner or Responsible Party

Date

Relationship to Patient