Patient History

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell Phone # _____ DOB _____/_____/_____ Sex M / F

Employer _____ Email _____

Insurance? Y / N Insurance Company _____

Please circle for each of the following:

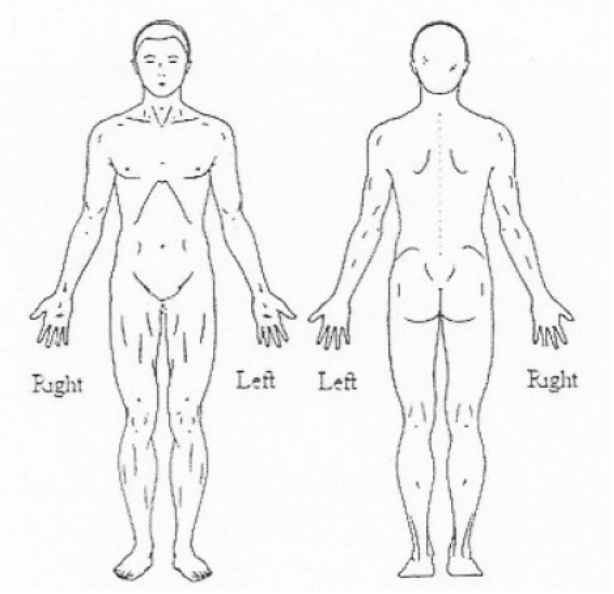
Prior Health History		**Description**	**Date(s)**
Prior Surgery?	Y / N	_____	_____
Hospitalizations?	Y / N	_____	_____
Auto Accidents?	Y / N	_____	_____

Current Health History

Did/do you smoke? Drink alcohol?	Y / N	_____	_____
Have you been in accidents/trauma?	Y / N	_____	_____
Obesity or need for weight loss?	Y / N	_____	_____
Drugs (prescription, OTC, recreational)?	Y / N	_____	_____

Have you received Chiropractic Care? Y / N **How long since last adjustment?** _____

Please circle your pain level: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)



Numbness	N
Dull Ache	D
Burning	B
Sharp/Stabbing	X
Pins, Needles	+
Other _____	O

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major _____ Minor _____

When did the pain/condition start? _____ How? _____

Pains are (circle one): Sharp Dull/Ache Constant Intermittent Other _____

Does this pain/condition shoot, radiate, or travel in your body? Y / N Where? _____

What activities aggravate your pain/condition? _____

What activities make it better? _____

Other Symptoms

Are you under medical care for any condition? _____

Allergies or persistent sinus issues? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Condition Like Yours
Father's side	○	○	○	○	○
Mother's side	○	○	○	○	○

Circle the items which relate to you or what you want help with.

WEIGHT LOSS ● Light therapy weight loss ● Medication weight loss ● Surgical weight loss	**MRI** ● Orthopedic imaging ● Internal/Other	**PAIN MANAGEMENT** ● Class IV Laser ● Medication ● Injections
WELLNESS TESTING ● Annual/Routine blood tests ● Thyroid testing ● Hormone testing	**ALLERGY TESTING** ● Grasses, Molds, Dander (sinus allergies) ● Food, Gluten (digestive issues) ● Contact Allergens (skin, lips, sensitivity)	

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation, make a treatment recommendation, and/or provide a medical referral for services not offered by this office. I understand this office does not provide x-ray services although x-rays may be recommended to me. I hereby release this office and its doctors from any and all liability in my election to be treated without x-rays. I have been fully informed of the risks of treatment and agree to pursue treatment without x-rays.

Patient/Guardian Signature _____ Date _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient: _____

Name of Patient: _____ Date: _____

If patient is a minor, please fill out the following:

Printed Name of Parent/Guardian: _____

Guardian/Parental Signature: _____

Relationship to Patient: _____ Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____ Date: _____