PATIENT HISTORY

(PLEASE PRINT)

Name_____ Social Security # _____

Phone: (hm): _____ (wk): _____ (cell): _____ Email: _____

Address: _____
(Apt #) (Street No.) (Street) (City) (State) Zip Code

Birth Date:_____ Age:_____ Marital Status: _____ Spouse's Name (or parent): _____
(M/D/Y)

Ages of Children (under 18): _____ Occupation: _____ Employer: _____

Work Address _____ How were you referred to this office? _____

Have you ever had Chiropractic care before?_____ If, "Yes", when? _____ By whom? _____

For what condition? _____ Date of last adjustment _____

LIST YOUR CHIEF COMPLAINTS (IN ORDER OF SEVERITY):

1. _____ For How long? _____

2. _____ For How Long? _____

3. _____ For How Long? _____

List other doctors consulted for this condition:

1. _____ Address _____

Do you have any health problems other than the ones listed? (Explain) _____

Are you taking any drugs or medications? (Name and what for) _____

How long has it been since you really felt well? _____

Is your condition interfering with your work? home life? sleep? (comments) _____

Is this injury or illness work-related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____ (If yes) Adjustor's Name _____

Auto insurance Co. _____ Policy # _____ Claim # _____ Phone # _____

Do you have any type of Health Insurance? _____ Company? _____

Address _____ Phone # _____ Policy # _____

Are you covered under any other group or individual health policy through yourself or spouse? _____

If yes, Company's Name _____ Phone # _____ Address _____

Spouse's Social Security # _____ Employer _____ Phone #_____

Method of Payment you plan to use for today's charges: ☐ Check ☐ Cash ☐ MasterCard ☐ VISA ☐ Discover

NOTICE: Not all patients require X-rays to determine or verify a diagnosis, type and length of care.
If your examination warrants X-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for X-rays is for analysis only. The film itself is the property of this office and cannot be released.

Patient's Signature (or guardian) _____ Date:_____

INFORMED CONSENT TO CHIROPRACTIC CARE

Doctors of chiropractic, medical doctors and physical therapists who use manual care techniques such as spinal adjustments are required to advise patients that there are or may be some risks, no matter how rare, associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic care.

Chiropractic care, including spinal adjustment, has been the subject of numerous government reports and multidisciplinary studies conducted over many years and has been demonstrated to be highly effective care for back pain, neck pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, drugs or pills, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic care offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date: _____

_____ _____

Patient Signature Witness

P.S.: If there is ever anything you have questions or concerns about please ask anytime. We are available to serve you.