WELCOME TO OUR OFFICE

Our Friendly & Courteous Staff Of Health Care Professionals Are Here To Help You!

Application and Consent For Treatment

Todays Date:_____

Patient Name:_____

Mailing address:_____

_____

Date Of Birth:_____ Phone Number_____

Age:_____ Social Security No:_____

Marital Status:_____

In case of emergency contact:_____Relationship _____

Phone:_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR AUTO INSURANCE CARRIER IF YOUR VISIT HERE TODAY IS RELATED TO A MOTOR VEHCILE ACCIDENT.

Insurance Company:_____

Policy Number:_____

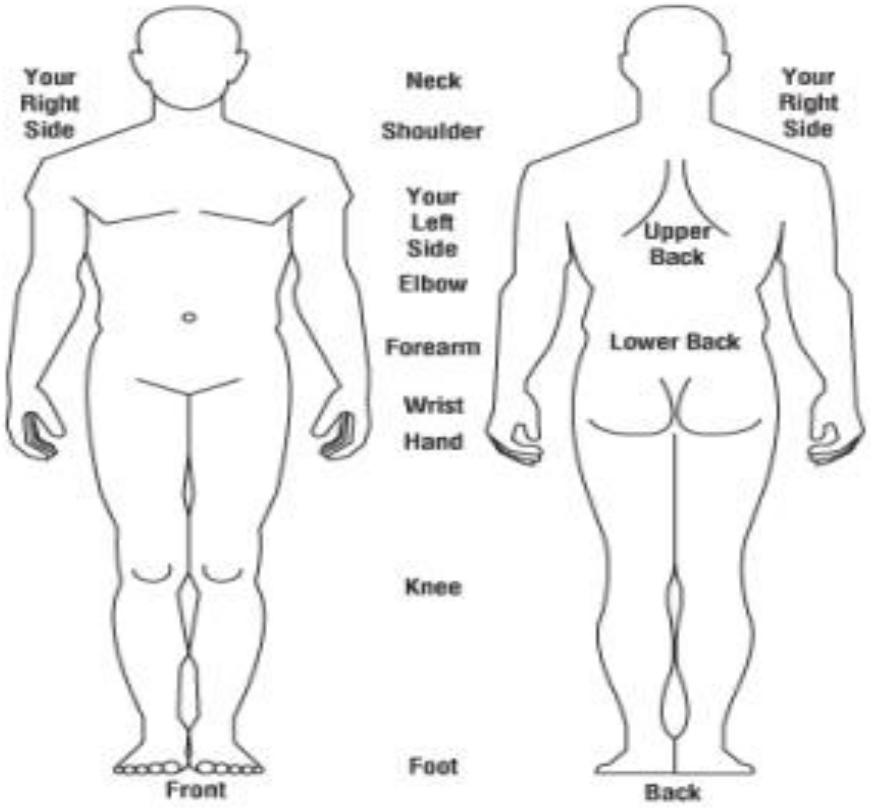
Claim Number:_____

Date of Injury:_____

Representing Attorney:_____

If you are in pain, please mark the exact location of your pain in the diagram below. Also describe the type of frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting etc, etc.

COMPLETE THESE DIAGRAMS



_____Notes to be completed by Doctor_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Please answer the following questions)

When and how did this condition start?

_____
_____
_____

What makes it better?

_____
_____
_____

Describe the pain (Sharp, Dull, Achy etc.)

_____
_____
_____

Does it radiate down the arms or legs, if so which side?

_____
_____
_____

When was the first time you were aware of this problem?

_____
_____
_____

Have you lost any days of work? ☐ YES ☐ NO If yes, what days:_____

Have you ever had this problem before? If yes please explain,

_____
_____
_____

Have you received any treatment for this condition? ☐ YES ☐ NO

If yes, please explain:

_____
_____
_____

Has this problem been getting better, worse, or staying the same?

_____
_____
_____

Have you been involved in any previous Auto Accidents? ☐ YES ☐ NO

If yes, please explain:

_____
_____

Have you ever had a slip & fall accident? ☐ YES ☐ NO If yes, please explain:

_____
_____
_____

Have you ever had any surgery? ☐ YES ☐ NO If yes, please list below:

_____
_____
_____
_____

(PLEASE CHECK OTHER SYMPTOMS YOU MAY BE EXPERIENCING)

☐ Headache ☐ Neck Pain ☐ Neck Stiff ☐ Sleeping Problems ☐ Back Pain ☐ Tension
☐ Nervousness ☐ Irritability ☐ Chest Pain ☐ Dizziness ☐ Head seems heavy ☐ Fatigue
☐ Pins & Needles in Arms ☐ Pins & Needles in Legs ☐ Numbness in Fingers ☐ Numbness in toes
☐ Shortness of Breath ☐ Ringing/ Buzzing in Ears ☐ Loss of Memory ☐ Face Flushed
☐ Light Sensitivity ☐ Loss of Balance ☐ Fainting ☐ Loss of smell ☐ Loss of Taste ☐ Stomachache
☐ Diarrhea ☐ Constipation ☐ Vomiting ☐ Nausea ☐ Fever ☐ Cold Hands ☐ Cold Feet
☐ Excessive Sweating
☐ Any additional not listed: _____

(PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING)

☐ Insulin ☐ Cholesterol ☐ Blood Pressure ☐ Anxiety
☐ Dietary ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Birth Control
☐ Other (Please List) _____

Are you Currently Pregnant ☐ YES ☐ NO

Have you ever been to a Chiropractor before? ☐ YES ☐ NO If yes, please list below:

Name_____Condition _____Date of last visit_____

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FEE'S ARE PAYABLE AT TIME OF EXAMINATIONS AND TREATMENTS ARE RECEIVED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

Patient Signature:_____
Last four of SS#_____
Date signed:_____

Informed Consent For Chiropractic Treatment

To the Patient: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not you have the treatment. This information is not mean to scare or alarm you, It is simply an effort to make you better informed so you may give or refuse your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic imaging. The treatment may be performed by the Doctor Of Chiropractic named below and/ or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below. In addition, we use trained staff personnel to assist the doctor with portions of your consultation, examinations, and treatment.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I under that, there are some risks to chiropractic treatment including the following but not limited to:

* Broken Bones
*Increased Symptoms
*Dislocations
*No Improvement of symptoms or Pain
*Sprains/strains
*Burns or Frostbite
*Worsening/ Aggravation of Spinal Conditions
* Patients taking Blood thinning medication and with bleeding disorders.

In rare cases there have been reported complications of vertebral artery dissection (Stroke) when a patient receives a cervical adjustment . A Stroke from a chiropractic adjustment is extremely rare, about 1 to 3 million and of those most reports have found underlying disease of the intima of the artery. www.chiro.org

Medication may be used to relieve pain and swelling. However, medication can progress the efficiency of Chiropractic treatment. Caution should be used and the side effects of such medication shoulder be well understood.

Non-treatment can result in adhesions, pain and reduction in associated joint mobility. The probability that these adhesions will interfere with the proper motion and function of the spine are very high. This can result in chronic conditions and lower quality of life.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient or patient representative:

Print Name: _____

Signature of patient or patient represenatative:_____

Date signed:_____

To be completed by doctor or staff:

Doctor Of Chiropractic:_____

Witness to patient's signature/ Translated by :_____

Date signed:_____