
Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Height

Address

Marital Status

Single Married
 Divorced
 Widowed Separated

Weight

City

State

Zip

Home Phone

Cell Phone

Spouse's Name

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

Patient First & Last Name

I do not take medications

Medication Name:

Dosage:

Allergies:

Any Significant Medical History or Surgeries (i.e., arthritis, asthma, cancer, auto-immune, depression, STD, hypertension, migraine, stroke):

Tobacco Use: No Daily Weekly Less Former/Year Quit: _____

Alcohol Use: No Daily Weekly Less Former/Year Quit: _____

Caffeine Use: No Daily Weekly Less Former/Year Quit: _____

Exercise Activity: Moderate Vigorous Sedentary Less Former/Year Quit: _____

Signature

Date (MM/DD/YYYY)



INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, physical therapy, podiatry, medical evaluation and treatment, vitamin injections, inter-muscular or joint injection, and any supportive therapies on me (or on the patient named below, for who I am legally responsible) by this clinic or office and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers name below, including those working at the clinic or offices listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with this location provider and/or with other office or clinic personnel the nature and purpose of the 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, 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 this provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve 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 payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options 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.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____