Welcome to our Chiropractic Office!

Please Print Clearly and fill In completely.

Print Name _____ **Email** _____

Street Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

Wellness Commitment

At our office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% --------20%-------- 30%-------- 40% --------50% --------60%-------- 70%-------- 80% --------90% --------100%

Where did you hear about our clinic,
or who referred you? _____

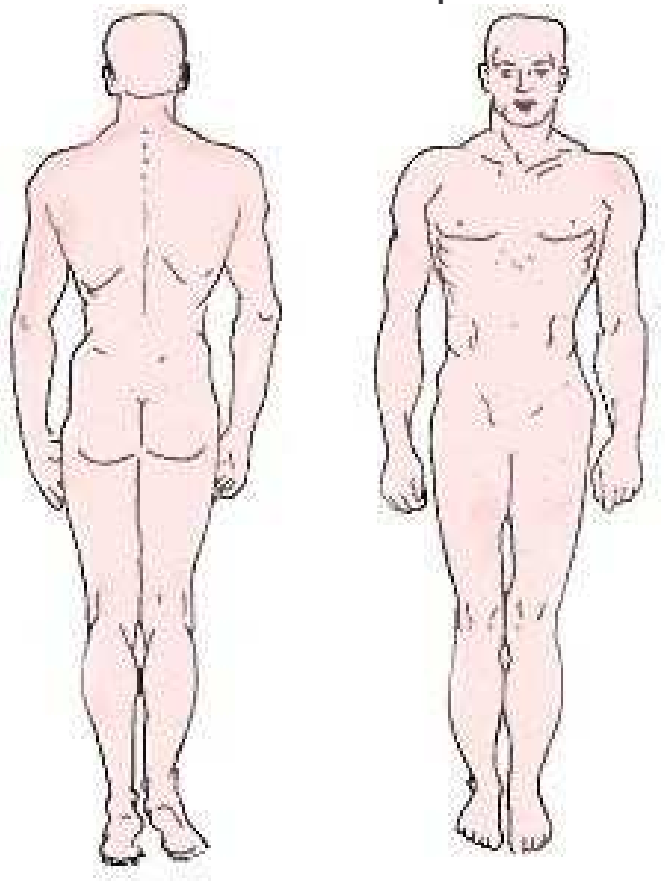
FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

Consent to Initiate Care

At our office, we have one simple goal. We want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some business procedures in this clinic to keep our fees reduced. Please read over these procedures below to understand how our clinic functions, and to decide if you wish to participate. If you have any questions please direct them to the receptionist.

1. Patients may choose to be cared for by any available staff doctors present on any given visit.
2. You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by our office. Our office takes *no responsibility* for non-payment by insurance companies for services rendered at our clinic.
3. Our office will not respond to *any* requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.
4. No balances can be kept or run by patients at any time.
5. All adjustment visits are paid immediately ***prior*** to the service being rendered.
6. All examinations and x-rays are paid upon completion of these services.
7. Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

To initiate care at our facility, there are two required visits you will be scheduled for. If you cannot attend either of these two visits, the negative impact on your care will be profound, and we cannot in good conscious initiate your care. These required visits are:

1. **Initial Interview and Examination:** *This visit will consist of a health history, chiropractic examination, and x-rays if needed. (This is probably the visit you are present for now) Total time about 30 – 45 minutes.*
2. **Report of Findings:** *This visit will consist of a detailed report of findings with recommendations for your care. Also included is information on chiropractic health and wellness. Recommendations on what to do between visits and a detailed explanation of your care plan. X-rays will also be reviewed at this time. We recommend that spouses and adult family members attend this visit with the patient. Children should not attend this visit as the material may be too advanced and children will find it difficult to stay attentive without becoming a distraction for that amount of time. Due to the time required, there are only certain times this visit is given. Check with our receptionist or one of our doctors for available times. Total visit time about 60 -75 minutes.*

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name _____ **Today's Date** _____

Sign your name _____