Application For Care

Tell Us About You

Name _____ Date of Visit _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

E-mail _____

Date of Birth _____ Age _____ Gender _____

Status (Circle One) *Minor* *Single* *Married* *Divorced* *Separated* *Widowed*

Referred By _____

Occupation _____ Employer _____

Spouse's Name / Contact Person _____ Phone _____

Minor Children's Names, Ages, and Health Status _____

_____

Have your children been checked by a chiropractor? *Yes / No* Chiropractor's Name _____

Health Information

What is your main concern? _____

_____

_____

What are your expectations? _____

_____

_____

How many glasses of water do you drink a day? _____

What do you do to keep yourself healthy? _____

_____

List Medications: _____

_____

Surgeries & Dates: _____

_____

Family Health History: _____

_____

_____

Do you smoke? *Yes / No* If so, why? _____

_____

Have you been to a chiropractor before? *Yes / No*

Chiropractor's Name _____

Date of Last Visit _____

Rate Your Stress

(Circle a number to rate each, 1 = min., 10 = max.)

Physical Stress *(i.e. heavy lifting, excessive driving, computer work)*

1 2 3 4 5 6 7 8 9 10

Chemical Stress *(i.e. exposure of toxins, medications, poor nutrition)*

1 2 3 4 5 6 7 8 9 10

Emotional Stress *(i.e. work, family, financial)*

1 2 3 4 5 6 7 8 9 10

List Major Stresses: _____

_____

List Major Traumas or Accidents & Dates: _____

_____

_____

For Women

Are you taking birth control pills? *Yes / No*

Are you pregnant? *Yes / No* Due Date _____

Number of Pregnancies _____ Number of Births _____

Vaginal Deliveries _____ C-Section Deliveries _____

Have you entered menopause? *Yes / No* When _____

Hysterectomy? *Yes / No* Date _____

Office Use _____

_____

DISCLOSURE *and* CONSENT *for* CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE CLIENT: You have a right as a client to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I certify that I'm the client or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine administer care as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I understand that I have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: the right to review the notice prior to consent, the right to request restrictions as to how my health information may be used or disclosed to carry out care, payment or health care operations.

As a Client of The Adjustatorium I understand that an open adjusting room is utilized, and with the nature of open adjusting rooms I acknowledge and accept that my personal information may be heard by another person in the office. If confidentiality is required, I agree to schedule a private appointment with The Adjustatorium staff to discuss my information.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name: _____

Signature of Client/or Representative: _____ Date Signed: _____

Member of Doctor's Staff: _____ Date Signed: _____