# INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist.

Today's Date: _____

Name: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: S M W D Number of Children: _____

Please circle one payment type: Cash Check Master Card/Visa American Express Personal Injury Automobile Insurance Policy

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Your Social Security #: _____

Do you have Medicare? Yes _____ No_____ Do you have Medicaid? Yes _____ No_____

Name of Spouse or Parent: _____ Their Birthdate: _____

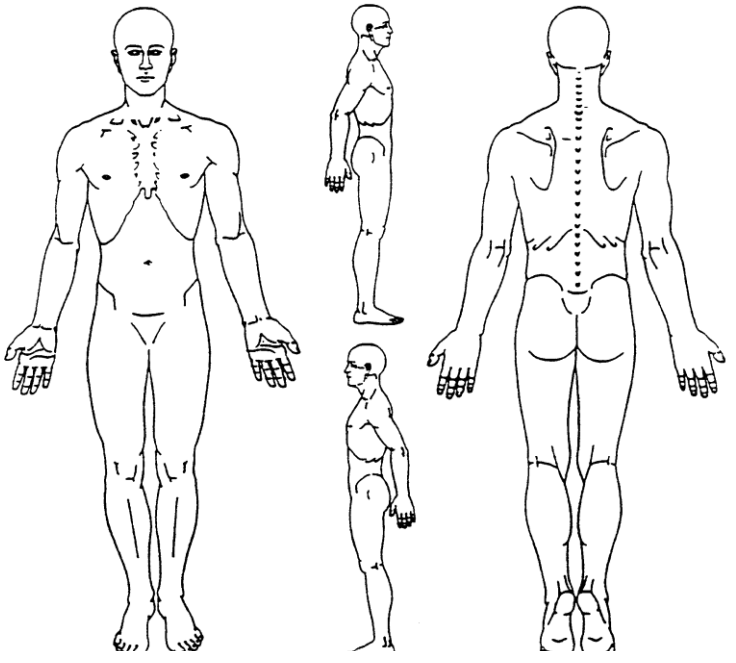
Spouse Employed By: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone #: _____ Spouse's SS#: _____ Driver's License #: _____

Does your spouse have health insurance at work? Yes_____ No _____

## COMPLETE THESE DIAGRAMS



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

## MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____

_____

_____

_____

_____

Referred to our office by: _____

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

I (we) agree to pay for service rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Or Guardian Signature: _____ Date: _____

# *INFORMED CONSENT*

## PATIENTS REQUEST FOR CHIROPRACTIC AND/OR PHYSIOTHERAPY CARE

Dear Patient, we would like to personally welcome you to our clinic. This notice is to advise you that every type of healthcare delivery system, including chiropractic care, has some associated risks and the potential for occasional problems of some kind. These problems can include temporary soreness, sprain-strain, bruising, burns, fractures, dislocations, disc injuries, stroke, etc. In considering these issues, remember that humans and their injuries are unique, and treatment that might be very effective for one person might not be as effective for another person. While we are committed to providing you with the best and safest treatment possible, we also have a legal responsibility to advise you about some very rare but potential problems that can occur with chiropractic care and/or physiotherapy. **Before you start your treatment, you need to review this information which is called your " informed consent." No treatment can begin until you have reviewed this document authorizing treatment based on your informed consent.** Please feel free to discuss any questions or concerns that you may have directly with the Doctor before any treatment at our office. **Remember, we always have time to talk with you about any concerns or questions.**

_____**Disc Herniations:** Non-surgical disc injury problems are frequently and successfully treated by skilled chiropractors. Occasionally, chiropractic treatment may aggravate a preexisting disc problem. Very rarely, chiropractic care may cause a disc problem to flare-up or even worsen, especially if the disc is already severely damaged before treatment begins.

_____**Soft Tissue Injury:** This term refers to injured muscles; tendons; ligaments; cartilage (and their attachments to bone); blood vessels; and nerves. At times, these tissues (or scar tissue) may be stretched, resulting in temporary pain.

_____**Rib Fractures:** Rarely, chiropractic adjustments may crack a rib bone. This risk is increased in elderly osteoporotic patients. We adjust all of our patients carefully, especially our older patients to minimize this risk.

_____**Burns:** Some of our physiotherapy equipment and/or modalities (hot packs, ice, ultrasound, etc.) work by generating heat or cold. Therefore, it is possible for a patient to be burned (by heat or ice) if they do not follow instructions or misuse the equipment. Usually, these are minor problems, but they can cause temporary redness, some swelling, and mild pain for a few days.

_____**Soreness:** Chiropractic adjustments, traction, massage, stretching exercises, etc., all have the possibility of making a patient sore, on a temporary basis.

If any problem starts to develop, please advise the doctor.

**Disclaimer:** Chiropractic is a health care delivery system, and as with any health care delivery system, we do not and can not promise or guarantee to cure any specific symptom, disease, or condition.

| _____ | _____ | _____ |
|---|---|---|
| Doctor's Signature | Patient's Signature | Today's Date |