Conditions you have had:

\_\_Aids/HIV \_\_Depression \_\_High Blood Pressure \_\_Prostate Problem

\_\_Alcoholism \_\_Diabetes \_\_High Cholesterol \_\_Prosthesis

\_\_Allergies \_\_Digestive Disorder \_\_Hypoglycemia \_\_Rheumatic Fever

\_\_Anemia \_\_Dizziness \_\_Neck Pain \_\_Sinus Troubles

\_\_Anorexia \_\_Epilepsy \_\_Nervousness \_\_Stroke

\_\_Arthritis/Joint Pain \_\_Fatigue \_\_ Neuritis \_\_Tuberculosis

\_\_Asthma \_\_Gout \_\_Numbness \_\_Ulcer

\_\_Backaches \_\_Headaches \_\_Osteoporosis \_\_Urinary Trouble

\_\_Bleeding Disorders \_\_Heart Troubles \_\_Pacemaker \_\_Weight Loss

\_\_Breathing Disorders \_\_Hernia \_\_Pinched Nerves \_\_Yeast/Candida

\_\_Cancer \_\_Herniated Disk \_\_Poor Circulation

**Habits:**

Do You Smoke? Y / N How Many / Day\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you smoked\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Coffee? Y / N Cups / Day \_\_\_\_\_\_\_\_\_\_\_\_ Drink Caffeinated Tea Y / N Cups / Day \_\_\_\_\_\_\_\_\_

Colas/Soft Drinks? Y / N Cups / Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glasses of Water / Day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcoholic Beverages? Y / N How many / Day \_\_\_\_\_\_\_\_\_\_ Week\_\_\_\_\_\_\_\_\_\_\_ Social \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Sleep Well? Y / N If No, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours / Night \_\_\_\_\_\_\_\_

Do You Have Sufficient Energy For Normal Activiities? Y / N If No, Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**XRAY History:**  (Include Cat Scan and MRI) When was most recent x-ray / other study? \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Age/Date Taken |  Body Area | Type( X-RAY, CAT, MRI) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 **Assignment and Release**

I, the undersigned certify that I (or my Dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

And assign directly to Complete Chiropractic Center all insurance benefits, if any, otherwise payable, that any missed appointment without 24 hour notice is subjected to a $25.00 fee. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent For Chiropractic Treatment**

I hereby consent and request to the performance of chiropractic treatments (also known as Chiropractic adjustments or manipulative treatments) and any other associated procedures; Physical examinations, tests, physio therapy, physical therapy, etc on me by the doctor and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those, complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers’ syndrome, diaphragmatic paralysis, cervical myelopathy and cost vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition (s) and for any future conditions (s) for which I seek treatment.

**Receipt Of Privacy Notice**

My signature, below, certifies that I have seen a copy of the NOTICE OF PRIVACY PRACTICES.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative Date