Patient Information Worksheet

Name: _____ Birth Date: ____/____/____ SS# _____Age:_____

Address: _____ City: _____State:_____ Zip: _____

Home Phone: (____) _____Cell Phone: (____)_____Work Phone: (___)_____

Email Address: _____ Employer: _____

Spouse Name: _____ Spouse Birth Date: _____/_____/_____

Referred By: (Friend) (Relative) (Internet) (Yellow Pages) (Drove By) (Other): _____

Are you receiving care from other health professionals? Yes No If yes, please state reason: _____

_____

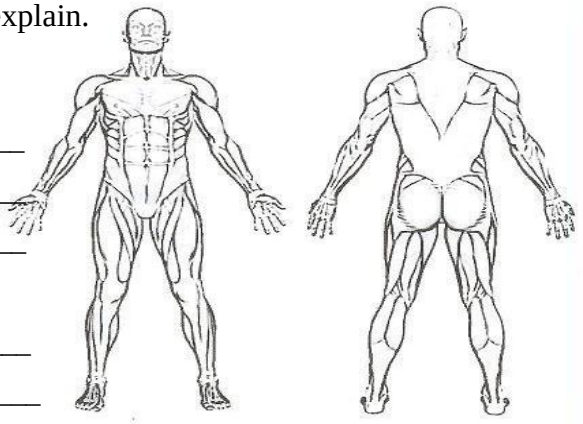
List any serious condition the doctor should be aware of: _____

Have you ever had spinal surgery? No Yes: _____

Please list any drugs, medications, vitamins/herbs/homeopathics/other you are taking: _____

_____

Where is the problem? Please use the illustrations and lines below to explain.



Has condition: gotten worse stayed constant comes and goes

Front_____

_____

_____

Back_____

_____

_____

Do you have □ Pain □ Numbness □ Tingling

Are symptoms affected by □ Sitting □Walking □Bending □ Lying down

Does this condition interfere with □ Work □ Sleep □ Daily Routine □ Other

Please explain: _____

_____

Office Policies: *If I am accepted as a patient to the Complete Health Chiropractic/Horst Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. In the event that I receive checks from my insurance company for services rendered at Complete Health Chiropractic/Horst Chiropractic, I understand that I am to sign the checks over to Complete Health Chiropractic/Horst Chiropractic immediately. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Continued on other side

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, physiotherapy modalities and if necessary, diagnostic procedure on me(or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Chiropractic Doctors of Complete Health Chiropractic/Horst Chiropractic. I have had an opportunity to discuss with **the doctors** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

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