Confidential Patient Health Record

Today's Date: ___/___/___

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs.

Last:_____ First:_____ Middle: _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Birth Date: ___/___/_____ Age:_____ Sex: Male / Female SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ First:_____ Middle:_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext ___

Work Phone: (_____) _____-_____ ext _____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

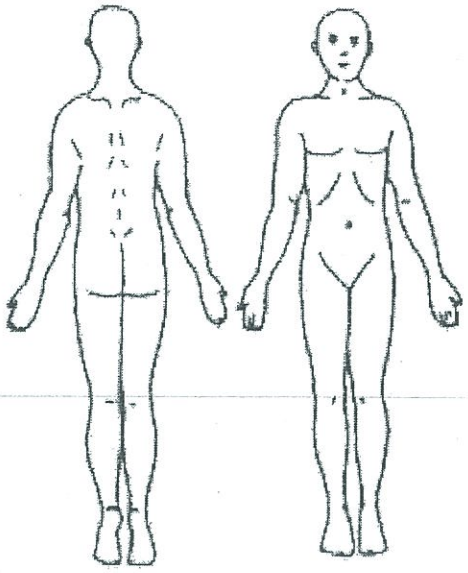
_____

Patient Name: _____ Date: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? ____/____/____

Has it ever occurred before? ☐ Yes ☐ No. When? _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss
☐ daytime drowsiness ☐ fever ☐ weight gain

Eyes/Vision: ☐ I DENY having any of the symptoms or problems listed below.

☐ blindness ☐ change in vision ☐ field cuts ☐ photophobia
☐ blurred vision ☐ double vision ☐ glaucoma ☐ tearing
☐ cataracts ☐ eye pain ☐ itching ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ history of head injury ☐ postnasal drip ☐ tinnitus (ringing in ears)
☐ difficulty swallowing ☐ fainting ☐ hoarseness ☐ rhinorrhea (runny nose) ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections
☐ dizziness ☐ headaches ☐ nasal congestion ☐ snoring

Respiration: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma ☐ coughing up blood ☐ sputum production
☐ cough ☐ shortness of breath ☐ wheezing

Patient Name: _____ Date: _____

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ angina (chest pain or discomfort)
- ☐ chest pain
- ☐ claudication (leg pain/ache)
- ☐ heart murmur
- ☐ heart problems
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ orthopnea (difficulty breathing lying down)
- ☐ palpitations
- ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)
- ☐ shortness of breath with exertion or exercise
- ☐ swelling of legs
- ☐ ulcers
- ☐ varicose veins

Gastrointestinal: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ abdominal pain
- ☐ belching
- ☐ black - tarry stools
- ☐ constipation
- ☐ diarrhea
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ hemorrhoids
- ☐ indigestion
- ☐ jaundice
- ☐ nausea
- ☐ rectal bleeding
- ☐ abnormal stool caliber
- ☐ abnormal stool color
- ☐ abnormal stool consistency
- ☐ vomiting
- ☐ vomiting blood

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

- ☐ birth control
- ☐ breast lumps/pain
- ☐ burning urination
- ☐ cramps
- ☐ frequent urination
- ☐ hormone therapy
- ☐ irregular menstruation
- ☐ pregnancy
- ☐ urine retention
- ☐ vaginal bleeding
- ☐ vaginal discharge

Male: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ burning urination
- ☐ erectile dysfunction
- ☐ frequent urination
- ☐ hesitancy/ dribbling
- ☐ prostate problems
- ☐ urine retention

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ cold intolerance
- ☐ diabetes
- ☐ excessive appetite
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ abnormal frequency of urination
- ☐ goiter
- ☐ hair loss
- ☐ heat intolerance
- ☐ unusual hair growth
- ☐ voice changes

Skin: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ changes in nail texture
- ☐ changes in skin color
- ☐ hair growth
- ☐ hair loss
- ☐ hives
- ☐ history of skin disorders
- ☐ itching
- ☐ paresthesias
- ☐ rash
- ☐ skin lesions / ulcers
- ☐ varicosities

Nervous System: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ dizziness
- ☐ facial weakness
- ☐ headache
- ☐ limb weakness
- ☐ loss of consciousness
- ☐ loss of memory
- ☐ numbness
- ☐ seizures
- ☐ sleep disturbance
- ☐ slurred speech
- ☐ stress
- ☐ strokes
- ☐ tremor
- ☐ unsteadiness of gait/ loss of balance

Psychologic: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ anhedonia
- ☐ anxiety
- ☐ loss or change in appetite
- ☐ behavioral change
- ☐ bi-polar disorder
- ☐ confusion
- ☐ convulsions
- ☐ depression
- ☐ insomnia
- ☐ memory loss
- ☐ mood change

Allergy: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ anaphalaxis
- ☐ food intolerance
- ☐ itching
- ☐ acute nasal congestion
- ☐ chronic nasal congestion
- ☐ rash
- ☐ sneezing

Hematologic: ☐ I DENY having any of the symptoms or problems listed below.

- ☐ anemia
- ☐ bleeding
- ☐ blood clotting
- ☐ blood transfusion
- ☐ bruising easily
- ☐ fatigue
- ☐ lymph node swelling

Patient Name: _____ Date: _____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for Same Condition: ☐ I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenzal pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythema (discoid)
- ☐ lupus erythema (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ pneumonia
- ☐ psoriasis
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- ☐ angioplasty
- ☐ appendectomy
- ☐ caesarian section
- ☐ cardiac catheterization
- ☐ carpal tunnel repair
- ☐ coronary artery bypass
- ☐ cosmetic
- ☐ D & C
- ☐ dental surgery
- ☐ gall bladder
- ☐ hemorrhoidectomy
- ☐ hernia repair
- ☐ hysterectomy
- ☐ joint reconstruction
- ☐ joint replacement
- ☐ knee repair
- ☐ laminectomy
- ☐ mastectomy
- ☐ pacemaker insertion
- ☐ rotator cuff
- ☐ spinal fusion
- ☐ tonsilectomy
- ☐ other:

Patient Name: _____ Date: _____

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt ☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Votech ☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree ☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking

☐ Smoke; #_____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____ cans per ☐ Day ☐ Week ☐ Year

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____-_____-_____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐No Date: ___/___/_____ Time: _____am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____-_____ Adjuster: _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL _____

ADDRESS _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please Print)

_____ _____

If Patient Is A Minor Signature Of Parent Or Legal Guardian Relationship to Patient

_____ _____

Witness To The Above Signatures Please Print Name

Houston Health & Wellness

2550 GRAY FALLS DR., #120
HOUSTON, TX 77077
(281) 496-3355 FAX (281) 496-4242

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FOR PRIVATE, GROUP, ACCIDENT AND HEALTH INSURANCE

Patient:_____ Insured:_____

Employer:_____

Claim/Group:_____ S.S.#/Policy:_____

I hereby instruct_____Insurance Company to pay by check made out and mailed to:

Houston Health & Wellness
2550 Gray Falls Dr., #120
Houston, TX 77077

If my current policy prohibits direct payment to doctor, then I also hereby instruct and direct you to make out the check and mail it to the doctor as follows:

Houston Health & Wellness
2550 Gray Falls Dr.,#120
Houston, TX 77077

For the medical expense benefits allowable under my health or P.I.P., and otherwise payable to me under my current insurance policy as payment toward the total charge for all services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance for all service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorized the release of any information pertinent to my case to you as the insurance company or attorney.

Date at___ _.m. this____day of ____,__.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than policyholder

HOUSTON
HEALTH & WELLNESS
2550 GRAY FALLS DRIVE, SUITE 120
HOUSTON, TEXAS 77077
Ph#:281-496-3355, Fax#:281-496-4242

PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND TREATMENT AGREEMENT

I hereby direct any and all insurance carriers, health benefit plan administrators and sponsors, health maintenance organizations, preferred and independent organizations, attorneys, at fault parties, at fault third parties, tortfeasors, individuals, and any other entities, which may elect or be obligated to pay or disperse proceeds to me for any reason to pay directly to, and exclusively in the name of, **Houston Health & Wellness,** in the amount of the full charges incurred by me at **Houston Health & Wellness** either now or in the future. Such charges shall include without limit in the normal fees for **Houston Health & Wellness** services as described below, interest to the extent permitted by law, and other charges incurred by me at **Houston Health & Wellness** (my Charges). For the purposes of this Agreement, any and all proceeds shall include the proceeds from any settlement, judgment, or verdict, as well as, without limit, the compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payment benefits, personal injury protection, lost wages, lost services, property damage, and malpractice.

I further grant a contractual lien to **Houston, Health & Wellness** with respect to my Charges; however, I understand that nothing in this Agreement by itself shall be construed as an election by **Houston Health & Wellness** to claim protection under any statutory lien law.

I further assign to **Houston Health & Wellness,** insofar as permitted by law, all of my rights, remedies, and benefits to **Houston Health & Wellness,** as well as any and all causes of action that I might have against such Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in **Houston Health & Wellness'** name, and the right to settle or otherwise resolve such causes of action as **Houston Health & Wellness** sees fit.

In the event that my treatment at **Houston Health & Wellness** relates to a personal injury, and I retain one or more attorneys to represent me regarding the personal injury matter, I direct each attorney to issue a letter of protection to **Houston Health & Wellness** regarding my Charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of **Houston Health & Wellness.** I further direct (and **Houston Health & Wellness** requests) each attorney to provide immediate notice to **Houston Health & Wellness** regarding any Proceeds received by the attorney relating to my personal injury, to promptly pay **Houston Health & Wellness** in full from such Proceeds, and to provide a full accounting of such Proceeds to **Houston Health & Wellness.**

I authorize and direct **Houston Health & Wellness** to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct **Houston Health & Wellness** to apply any Proceeds received from the Payer to any reductions, write-offs, or discounts, issued by another.

I authorize **Houston Health & Wellness** to endorse or sign my name on any checks listing me as payee which are received by **Houston Health & Wellness** for payment of Charges incurred by me, my spouse, or my dependents. I further authorize **Houston Health & Wellness** to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

In consideration for **Houston Health & Wellness** services, I agree to pay to **Houston Health & Wellness** its normal fee for such services. Nothing in this agreement requires **Houston Health & Wellness** to await payment for past Charges or for Charges that accrue, and I agree to pay all accrued Charges in full upon demand. If **Houston Health & Wellness** must take action to collect from either me or any Payer, I will be responsible for the costs of such collection efforts including, without limit, court costs and attorney fees. I hereby waive any statue of limitations which may apply to the collection of my Charges.

This Agreement shall not be modified or revoked without the mutual written consent of **Houston Health & Wellness** and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection and the rights and interest of **Houston Health & Wellness** and myself. However, should any provision of this Agreement be found invalid, illegal, or unenforceable, or for any reason cease to be binding on any part hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effort.

Patient Name (please print): _____

Patient Signature (complete): _____ Date: _____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian Signature: _____

_____

As representative for the third party administrator, insurance adjustor, legal council, at fault party, or any other entities, I agree to honor this lien and at time of settlement make direct payment for services rendered to **Houston Health & Wellness.** Payment will be made payable to **Houston Health & Wellness** and mailed to the following address of:

Houston Health & Wellness
2550 Gray Falls Drive, Suite 120
Houston, Texas 77077

Company Name: _____

Representative's Name (please print): _____

Representative's Signature: _____Date: _____

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

RELEASE OF INFORMATION:
By signing this form, you are granting consent to **HOUSTON HEALTH & WELLNESS** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 281-496-3355. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION
THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:
1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.
Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable. If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program. Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

Research concerning the rehabilitation program and results may be conducted. Data will be used from the participant's evaluations and exercise program. No names will be used and all information is strictly confidential.

Initial _____

Chiropractic, as well as all other health professions, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Chiropractic adjustments and physical therapy procedure are sometimes accompanied by post treatment soreness, disc injury aggravation, minor joint, ligament, tendon, or other soft tissue injury, minor burns to the skin while receiving moist heat as well as rare rib injury or fracture from thoracic spine adjustments. Stroke is the most severe complication of Chiropractic treatment, as well as the least occurring; with the estimated incidence of this type of side effect are 1 in 3 million upper cervical adjustments (JMPT 1996; 19; 37). Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. These are not a normal and acceptable accompanying response to chiropractic care and physical therapy. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms.

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained. I understand that the practice of medicine is not an exact science and **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of any procedure. I consent to diagnostic studies, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below, related to the procedure described herein. I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Doctors at this facility and any other physicians or other medical personnel who may be involved in the course of my treatment.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

X _____
Print Patient's Name

X _____
Patient's Signature

X _____
Other Than Patient, Print Name & Relationship

X _____
Witness