Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____ by the licensed Doctor of Chiropractic in this clinic.

I have had an opportunity to discuss with the doctor the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment.) I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my exam and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

I understand that this is a cash practice, and full payment is expected upon completion of each treatment. I will pay the full amount after each treatment.

Female Patients: Please let the Doctor of Chiropractic know if you are pregnant as soon as you find out.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed by Patient

Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. Thank you.

Name_____ Birthday_____ Sex_____

Address_____ City_____ State____ Zip____

Soc. Sec.#_____ Home Phone_____ Work_____

Cell_____ E-mail_____

Marital Status_____ Children, ages_____ Spouse's Name_____

Occupation_____ Employer_____

How did you hear about us?_____

What is your major complaint?_____

_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Does anything make it worse?_____

Does anything make it better?_____

Is this condition (circle): Improved Unchanged Getting worse

Is this condition interfering with your (circle): work sleep daily routine _____

Other doctors or therapists who have treated THIS condition_____

_____

Do you have a family physician? Name_____

Medications, dosage and frequency:_____

_____

_____

Have you ever been in an auto accident or had any other personal injury? Yes No

If yes, describe_____

Signature_____ Date_____

Parent/Guardian_____ Date_____

Focused Health & Wellness Center
Michelle Eddy, D.C.