Date: _____

Welcome to Carey Chiropractic

Last_____ First_____ Middle Initial____ Birth Date_____ Age_____
Address_____ City_____ State_____ Zip_____
Phone (H) _____ (C) _____ E/mail _____
Occupation_____ Employer_____
Spouse's Name_____D.O.B_____ Employer_____
Children's Name & Ages_____
Have you had previous Chiropractic care? Yes____ No____ Positive Experience? Yes____ No____
Who may we thank for referring you to our office? _____Walk In___ Google___ MD Referral___
Who is your primary care Physician? _____ Date of last physical/exam_____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.
Current Complaint: _____ Date when symptom first appeared:_____
How did it begin? _____
How often do you experience these symptoms?
Constant 100%___ Frequent 75%___ Intermittent 50%___ Occassional 25%___ Rare 10%___
Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme) _____
Have you ever experienced the same or similar symptoms? Yes____ No____ When? _____
Have you been to another doctor for this problem? Yes____ No____ Who/Where? _____
Type of pain: Sharp___ Dull___ Ache___ Burn___ Throb___ Do you have Tingling? Yes___ No___
Does the Pain Radiate? Yes___ No___ If yes, where? _____
What makes the symptoms increase? _____What relieves the symptoms? _____
Do any family members suffer from the same complaint? If so, who? _____
Are you interested in learning more about nutrition and supplementation? _____

Have you ever been in an auto accident? Past Year___ Past 5 Years___ Over 5 Years___ Never___
Please describe: _____
Please list ALL surgeries, injuries, accidents, falls, etc: _____
_____
List all Medications/Vitamins: _____

Do you smoke? Yes___ No___ If yes, how much/day? _____ Have you ever smoked? Yes___ No___
Do you consume alcohol? Yes_____ No_____ If yes, how many drinks/week? _____
Do you consume caffeine? Yes_____No_____ If yes, how many drinks/week? _____
Do you exercise? Yes___ No___ If yes, how many times/week and what type?_____
Do you have a high stress level? Yes___ No___ If yes, list reasons: _____
Is there any possibility that you may be pregnant? Yes___ No___
Date of Last Menstrual Cycle_____

Health History – Please circle all that apply

AIDS/HIV Allergy Shots Anemia Anorexia Appendicitis Arthritis Asthma Bleeding
Breast Lump Bronchitis Bulimia Cancer Cataracts Chicken Pox Depression Diabetes
Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis
Hernia Herniated Disc Herpes High Cholesterol Kidney Disease Liver Disease Measles
Migraines Miscarriage Mono M.S. Mumps Osteoporosis Parkinson's Polio Pacemaker
Pneumonia Prostate Prosthesis Implants Rheumatoid Stroke Thyroid Tonsillitis
Tuberculosis Tumors Typhoid Ulcers V.D. Whooping Cough Fatigue High Blood Pressure
Fibromyalgia Other _____

Name: _____

Date: _____

Family History – List any diseases and conditions that are current health problems of family members.

_____

_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand that and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____

Patient Acknowledgement and Receipt of Notice of Privacy Pursuant to HIPPA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State Law and Federal Law.

Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Carey Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Carey Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment benefits. However, I clearly understand that I am personally responsible for all costs of treatments rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____