

(over please)

Are you on medication? ☐ Yes ☐ No If yes, please list:

Medication	Reason for taking

Have you had surgeries in the past? ☐ Yes ☐ No If yes, please list:

Reason for surgery	Approximate date of surgery

Social and Occupational History:

What are the physical demands of your job? _____

What are your recreational activities including your physical exercise activities? _____

What are your personal health goals? (For example, weight loss, cessation of smoking, physical fitness, etc.) _____

What is your level of stress right now in the following areas?

Please mark from 1 (no stress) to 9 (very stressed)

physical _____ mental _____ social _____ emotional _____ chemical _____

Consent to Chiropractic Adjustments/Manipulations and Management:

I hereby request and consent to the performance of chiropractic adjustments/manipulations and other chiropractic management including various modes of physical therapy and diagnostic x-rays on me by Dr. Daniel Wilhelmus, Chiropractor and/or Dr. Angela VanDeWalle, Chiropractor and/or Dr. Dwayne Willaert, Chiropractor and/or Dr. Ashley Duesling, Chiropractor and/or anyone working in this clinic authorized by the doctors.

I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with the other clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand results are not guaranteed.

I understand and I am informed that, as in all health care, in the practice of chiropractic there is small risk of injury. These injuries include but are not limited to strains, sprains, disc injuries, rib fractures, as well as strokes. 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 judgment during the course of the procedure which the doctor feels at the time, based on facts known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its contents, and by signing below agree to the above 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.

To be completed by the patient with a witness present.

Name (Please Print) _____ Signed _____

Date _____ Witness _____

Privacy Act Acknowledgement:

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professionals Act (RHPA) and for the defense of a legal issue.

Our office will not, under any conditions, supply your insurer with your conditional medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information and we will explain the ramifications of that decision, and the process.

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code and I can ask to see the Code at any time. I agree that Family Chiropractic can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.

Signed _____ Date _____ Witness _____