Dr. Craig McDowell

Telephone (864)-489-0008
Fax (864)-489-8008
Toll free (866)-923-0008

Dr. Kim Ehlich-McDowell

717 Chesnee Highway
Gaffney, S.C. 29341
www.thefamilywellnesssolution.com

EHLICH FAMILY CHIROPRACTIC

"A World of Health Awaits You"

PLEASE PRINT

DATE_____

Name_____ SS# _____
Address_____ City_____ State_____ Zip Code_____
Phone #_____ Age____ Date of Birth_____ Sex ___ Marital Status _____
E-Mail Address _____ Spouse's Name_____
Your Occupation_____ Employed By_____
Work Address_____ Work Phone#_____
Work Schedule_____ Cell Phone #_____
Is it OK to call you at work? _____ Drivers License #_____ Children's names and ages_____

Have you ever been to a Chiropractor before? _____ If so, when? _____
How were you referred to our office? _____

How can we help you?:

1.) _____ 4.)_____

2.) _____ 5.)_____

3.) _____ 6.)_____

List others consulted for these conditions.

1.) _____ 3.) _____

2.) _____ 4.) _____

If this injury is work related or an auto accident, please report upon entering.

FEMALES – Are you pregnant? Yes_____ No_____ Not sure_____

1.) All first visit charges are payable when services are rendered.
2.) Method of payment you plan to use to take care of today's charges?
Cash_____ Check_____ Credit/Debit_____

3.) Please check other health concerns that you have experienced and rate the severity 0 being no pain and 10 being severe..

1.) Headaches/Migraines _____

2.) Dizziness _____

3.) Sinus _____

4.) Allergies _____

5.) Indigestion _____

6.) Heartburn _____

7.) Trouble Sleeping _____

8.) Gas, Constipation, or Diarrhea _____

9.) Stomach Trouble/Colic _____

10.) Nervous Stomach _____

11.) Ulcer _____

12.) Numbness/tingling _____
Where? _____

13.) Hernia _____

14.) Cancer _____

15.) Eczema _____

16.) Mood Swings _____

17.) Hot Flashes _____

18.) Night Sweats _____

19.) Low Libido _____

20.) Compulsive Tendencies _____

21.) High Blood Pressure _____

22.) Low Blood Pressure _____

23.) Diabetes. Is it in your family? _____

24.) Asthma _____

25.) Thyroid problems _____

26.) Period Trouble _____

27.) Any pain in your neck, _____
shoulders _____ or arm? _____

28.) Mid back _____

29.) Low back, _____ legs _____
or hips _____

30.) Kidney Problems _____

31.) Knee Pain _____

32.) Heel Spurs _____

33.) Hemorrhoids _____

34.) Blood clots _____

35.) Ear infections _____

36.) Irritability _____

37.) Difficulty Losing Weight _____

38.) ADD/ADHD/Trouble Focusing _____

39.) Anxiety _____

40.) Learning Disabilities _____

What surgeries have you had? _____

What broken bones have you had? _____

What drugs or prescribed drugs are you taking? _____

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Ehlich Family Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Ehlich Family Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate my care in this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize the Ehlich Family Chiropractic Clinic to obtain a credit report if necessary.

Patient's signature _____ Date _____

[Complete in office]

Complete if patient is a minor _____ Date _____

(Parent/Guardian signature)

In case of an emergency, notify _____

(Name of closest relative)

_____ _____

(relationship) (address)

_____

(phone)

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) [Complete in office] (date)

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PATIENT REQUEST FOR RECORDS

DATE: _____

TO: _____
(DOCTOR OR HOSPITAL)

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

I HEREBY AUTHORIZE THE RELEASE OF MY _____
_____ OR COPIES OF SUCH AND REQUEST
THAT THEY BE TRANSFERRED TO:

EHLICH CHIROPRACTIC CLINIC
717 CHESNEE HWY.
GAFFNEY, SC 29341
864-489-0008
864-489-8008 FAX

PATIENT NAME (PLEASE PRINT): _____

PATIENT SIGNATURE: _____

[Complete in office]

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Authorization to Release Information

I authorize the Ehlich Chiropractic, P.C. to send my family physician information concerning my care. I do have the option to revoke this authorization by notifying the Ehlich Chiropractic, P.C. in writing that I wish to do so.

_____
Physician name

_____ _____
Patient signature [Complete in office] Date

_____
Witness [Complete in office]

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DRS. CRAIG AND KIM MCDOWELL, D.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this Acknowledgement"

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please print name Date

_____
Signature [Complete in office]

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____
_____
_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, 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 and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited 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 secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____
[Complete in office]

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____
[Complete in office]

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____
[Complete in office]

Date:_____

Click Here To Submit Completed Form