Valley Chiropractic & Wellness

Who may we thank for referring you? **Today's date**

Your Last Name

Your First Name **Your Middle Name (Or Initial)** **Birth Date (MM/DD/YYYY)**

Address

City **State** **ZIP/Postal Code**

Cell Phone **Home Phone** **Spouse's Name** **Spouse's Birth Date**

Your Occupation **Your Employer**

E-Mail Address

May we text or email you appointment reminders one day before your next appointment?
◯ **text**: my cell phone company is (please circle) Verizon T-Mobile Sprint AT&T Nextel
◯ **email**: my email is written above

Emergency Contact **Phone**

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties**

Initials _____ **I grant permission to be called/texted to confirm or reschedule an appointment.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature of Patient/Guardian Date (MM/DD/YYYY)

CONFIDENTIAL HEALTH INFORMATION

Valley Chiropractic & Wellness **Patient Name: _____ Date: _____**

Describe onset of pain:_____ Injury Date: _____

Describe discomfort: _____

Received treatment elsewhere: _____ X-rays or imaging: _____

Health History: **Height: _____ Weight: _____**

Primary Physician: _____ Last physical exam: _____

Health conditions: _____

Previous chiropractic care: _____ Last adjustment: _____

Medications & Supplements: _____

Broken bones: _____ Strains/sprains: _____ Stroke:_____

Hospitalized: _____ Surgery: _____

Previous auto accidents: _____ Implants, pins or screws: _____

Health Checklist: **please circle**

osteoporosis	**scoliosis**	**loss of smell, vision or hearing**	**heart attack**	**diabetes**
back problems	**knee injuries**	**dizziness**	**chest pains**	**thyroid problems**
arthritis	**anxiety**	**headaches**	**high cholesterol**	**hair loss**
poor posture	**depression**	**high blood pressure**	**asthma**	**skin cancer**
neck pain	**weakness**	**low blood pressure**	**allergies**	**eczema**
			kidney stones	**psoriasis**

Family History of Illness: _____

Work Habits: _____ hours per week. Recent changes in work habits: _____

(Please Circle) Mostly sitting/standing/walking. Light/moderate/heavy labor or sedentary. Difficult/enjoyable/relaxed/ stressful.

Do you smoke/ drink alcohol/ drink caffeine/ use drugs? How much? _____

Exercise habits: activities_____ times per week_____

Diet changes: _____

Other information you would like the doctor to know about: _____

_____

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INFORMED CONSENT TO TREAT

I request and consent to the performance of procedures including chiropractic adjustments, examinations, cold laser therapy and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the licensed providers and support staff employed by Valley Chiropractic and Wellness. Please consult your doctor if you are pregnant as this is not a recommended treatment. All others, please use at your own risk. A user manual is available upon request.

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 also understand and am informed that 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 of improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect Valley Chiropractic and Wellness 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 to be in my best interest, based upon the facts then known.

I understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, 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.

I understand that there are other treatment options available for my condition including, 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 that I have the right to a second opinion and secure other options about my circumstances and health care as I see fit.

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: _____ Date:_____

I hereby give consent for this office to administer chiropractic as deemed necessary for my child.

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

Guardian/Parental Signature:_____ Date: _____