Waccamaw
Chiropractic & Wellness Center

DR ____________ FILE # ____________ DATE OF LAST VISIT ____________

PATIENT HISTORY UPDATE

Name: ____________________ DOB: ____________ Date: ____________

Address: ____________________ City/State/Zip: ____________________

Phone: ____________________ Email: ____________________

In case of emergency, please contact (include phone #) ____________________

Would you like to receive EMAIL or TEXT reminders? (Circle One) YES (EMAIL OR TEXT) NO

Insurance Company AND Member #: ____________________

Secondary Insurance AND Member #: ____________________

Medications: List ALL current or CIRCLE NONE ____________________

____

Vitamins: List ALL current or CIRCLE NONE ____________________

____

Allergies: List ALL or CIRCLE NONE ____________________

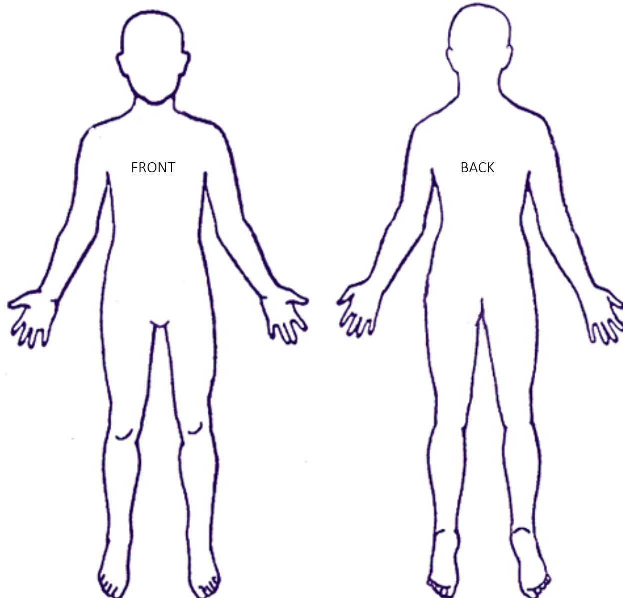
____

Past Surgeries: List ALL or CIRCLE NONE ____________________

____

You're Current Condition: Please indicated on the diagram below where you are experiencing the following symptoms:

A= Ache B= Burning N= Numbness P= Pain S= Stabbing O= Other



Please check any symptoms that apply:

____ Arm pain Right or Left
____ Hand pain Right or Left
____ Neck pain Right or Left
____ Neck stiffness Right or Left
____ Chest Right or Left
____ Shoulder pain Right or Left
____ Upper back pain Right or Left
____ Mid back pain Right or Left
____ Low back pain Right or Left
____ Leg pain Right or Left
____ Foot pain Right or Left
____ Hip pain Right or Left
____ Buttocks pain Right or Left
____ Numb/ tingling Right or Left
____ Dizziness

Please check any of the conditions you are experiencing or have been diagnosed with:

___ Allergies	___ Disc problems	___ Infertility	___ Prostate problems
___ Arthritis	___ Ear noises	___ Insomnia	___ Rosacea
___ Bursitis	___ Emphysema	___ Kidney trouble	___ Scoliosis
___ Cancer	___ Epilepsy	___ Life trouble	___ Sinus infection
___ Constipation	___ Frequent Urination	___ Multiple sclerosis	___ Stomach trouble
___ Diarrhea	___ Headaches	___ Nervousness	___ Stroke
___ Diabetes	___ Heart/ Circulatory	___ Neuritis	___ Vision problem
___ Difficulty Breathing	___ High blood pressure	___ Pinched nerve	Other___________________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: ____ Date: ____

CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, diagnostic x-rays, and nutritional products on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors at Waccamaw Chiropractic and Wellness Center.

I understand that nutritional information or suggestions are not intended to diagnose, cure, or prevent disease. Nutritional supplement are used to support normal body function.

I have had the opportunity to discuss with the doctor and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to exam and 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 doctors to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then knowing, is in my best interest.

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 entire course of treatment.

I authorize payment directly to the doctor from my insurance company and I clearly understand that I am responsible for payment should my insurance company deny payment or make payments directly to me. I understand the initial visit fees are due and payable at the time of service.

To be completed by patient:

____ X ____ _____________________

Print Your Name Signature Date

If patient is a minor or physically or legally incapacitated. To be completed by Patient's Representative:

____ X ____ _____________________

Print Name of Patient's Representative Signature of Patient's Representative Date

As: ____

Relationship or Authority of Patient's Representative

TO LEARN MORE, PLEASE VISIT US AT: **WWW.WACCAMAWCHIROPRACTIC.COM**