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 _____

_____

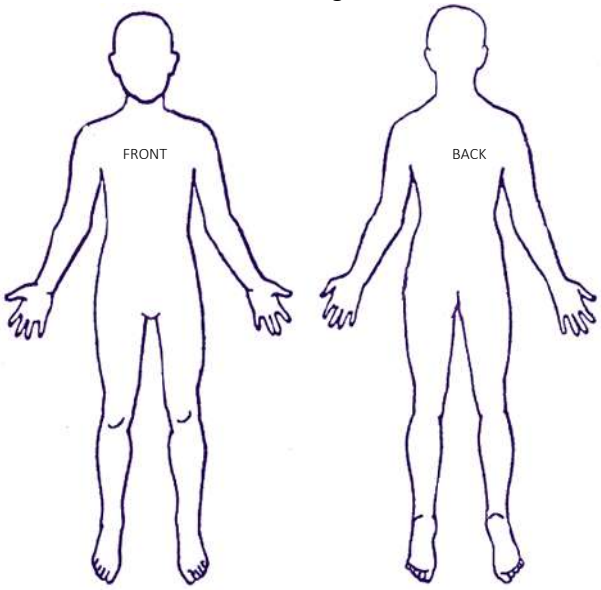
Allergies: List ALL or CIRCLE NONE _____

_____

Past Surgeries: List ALL or CIRCLE NONE _____

_____

Your Current Condition:
Please indicate 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	RATE YOUR PAIN 1 - Mild pain 10 - Severe pain	WHICH SIDE?
____ 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 see OTHER SIDE...

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**