Waccamaw Chiropractic & Wellness Center

Dr. John Evans
Dr. Jeff Evans

658 Wachesaw Rd., Murrells Inlet, SC 29576
(843) 357-9617 Fax (843) 357-9639

Dr. John / Dr. Jeff Type:_____

FILE # _____ Note:_____

☐ **CONSULT ONLY**

FOR OFFICE USE ONLY

Name: _____ Date: _____

Street Address: _____ City/ State: _____ Zip: _____

Billing Address: _____ City/ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email:_____

Would you like to receive EMAIL or TEXT reminders? *(circle one)* YES (EMAIL OR TEXT) NO

Occupation: _____ Employer: _____

Age: _____ Date of Birth: _____ Sex: M F Marital Status: Married Single Widowed

Number of Children: _____ Spouse's Name: _____ Employer: _____

Name of person responsible for payment (if different from applicant):_____

Would you like us to file your insurance? (circle one) YES NO

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

Previous Chiropractic care? YES NO If yes, previous Chiropractors Name _____

When was your last chiropractic evaluation/ treatment? _____

Primary Care Physician: _____

Who may we thank for referring you to our office? _____

Goals For Your Care: *Please check the type of care desired to help us when considering your care plan*

☐ **Relief Care**	☐ **Corrective Care**	☐ **Comprehensive Care**	☐ **Doctor Decides**
Symptomatic Relief of Pain or Discomfort	Correcting & Relieving the cause of the problem as well as the symptom	Designed to improve overall health and maximize body function	Allow the Doctor to select the type of care that is best for me

I am interested in: Massage Nutrition/ Detox Weight Loss Wellness Classes Blood Work

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CURRENT CONDITION CONTINUED

Major Complaint or reason for visit_____

When did this/ these conditions begin? _____

What is the cause of your condition? _____

Symptoms are aggravated by? _____

Symptoms are relieved by? _____

Any previous treatment for the current condition(s)? _____

Medical History

Family History: (AND RELATION)
_____ Diabetes _____ Cancer _____ Back Pain
_____ Stroke _____ Heart Disease

Other _____

Social History:
____ Smoking ____ Alcohol ____ Caffeine ____ Exercise
Packs per day ____

Recent Tests Performed (within the last year)

____ MRI ____ X-Ray ____ Blood Work

Medication(s): List **ALL** current or circle NONE

_____

_____

_____

Vitamin(s): List **ALL** current or circle NONE

_____

_____

Allergies: List **ALL** current or circle NONE

_____

_____

Past Surgeries: List **ALL** current or circle NONE

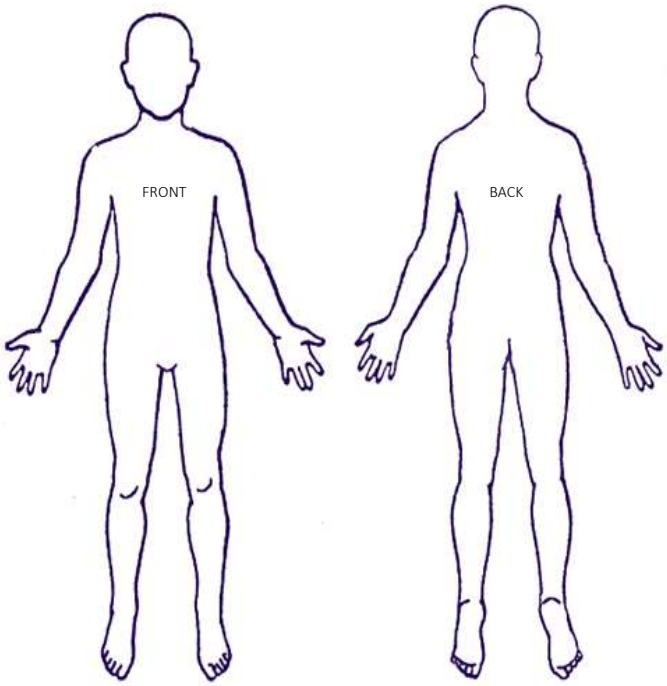
_____

_____

The following questions are regarding 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:

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

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.

MASSAGE CANCELATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled massage appointments to be cancelled at least 24 hours in advance.

Our doctors & massage therapists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled massage appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of April 1, 2018 there will be a fee of $25.00 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

To be completed by patient:

_____
Print Your Name

X _____ _____
Signature Date

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

_____
Print Name of Patient

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

As: _____ _____
Relationship or authority of Patient's Representative Date

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