Waccamaw
Chiropractic & Wellness Center

Case History Update

Name: _____ Date: _____

Has your address changed? Circle One Yes No

New Address: _____

City: _____ Zip: _____

Has your phone number changed? Circle One Yes No

New Home Phone: _____

New Work Phone: _____

Has your insurance company changed? Circle One Yes No

New Insurance Company: _____

Medication(s): List ALL current or CIRCLE NONE

_____

_____

Vitamin(s): List ALL current or CIRCLE NONE

_____

_____

Allergies: List ALL or CIRCLE NONE

_____

_____

Past Surgeries: List ALL or CIRCLE NONE

_____

_____

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

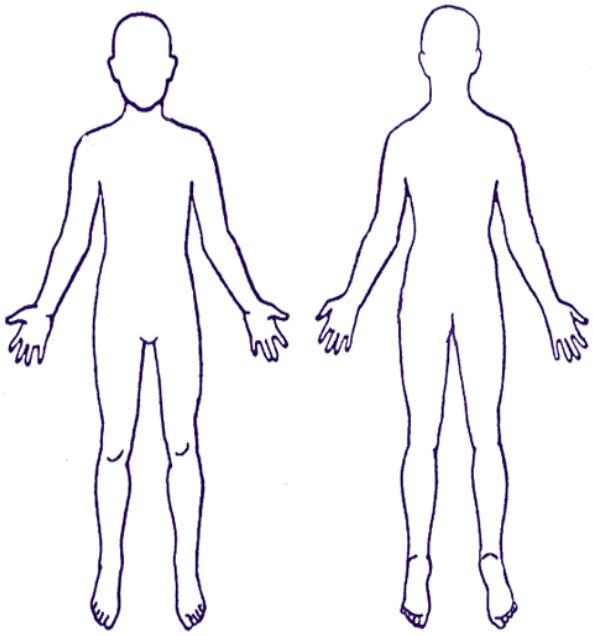
Patient Signature: _____ Date: _____

The following questions are regarding you 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	
____ Dizziness	

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

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

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:

_____
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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Appointment Cancellation 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 May 1, 2015 there will be a fee of $15.00 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.

_____ _____

Signature **Date**