



List past Surgical Operations with approximate dates: \_\_\_\_\_

List other complaints \_\_\_\_\_

List Medications if any: \_\_\_\_\_ Purpose? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any history of the following: (please circle)

Cancer

AIDS

Stroke

Tuberculosis

Diabetes

Heart Disease

Have you ever seen a Chiropractor before?  No  Yes - Approximate date of last treatment \_\_\_\_\_

**For Women Only:** Are you pregnant?  No  Yes - Due date? \_\_\_\_\_

To help us better explain your chiropractic condition and how we may be able to benefit your needs, please answer the following:

What are your goals for care?

- Symptomatic pain relief only
- Correction of the problem
- Wellness care

### CONSENT TO CHIROPRACTIC SERVICES

I authorize the performance upon myself or upon my named child \_\_\_\_\_  
the following procedures the Doctor deems necessary:

*Chiropractic examination, spinal adjustments, intermittent traction, disc decompression therapy, ice therapy, light therapy, ultrasound, muscle stimulation therapy, and/or x-rays if needed.*

I understand the nature and purpose of the procedures, possible alternatives, and the risks involved will be explained to me by the Doctor before treatment occurs. I also understand that I, as a patient, am responsible to ask the Doctor any questions or concerns regarding treatment procedures in this office.

I understand that my health information will be kept private and that I do have rights to that information upon request. An informational booklet is available at this office for review on how we use your information.

\_\_\_\_\_  
Patient or Authorized Signature

\_\_\_\_\_  
Date