CHIROPRACTIC DISCOVERY & WELLNESS
X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed

Please choose one:

_____ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

_____ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken it is possible to injure the fetus.

I have been advised that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising the doctor that:

I am pregnant	_____ yes	_____ no	_____ don't know
I could be pregnant	_____ yes	_____no	_____ don't know
My menstrual period is late	_____ yes	_____ no	
I have an IUD	_____ yes	_____ no	
I have had a tubal ligation	_____ yes	_____ no	
I have had a hysterectomy	_____ yes	_____ no	
I have irregular menstrual periods	_____ yes	_____ no	
My last menstrual period began	_____		
I have begun menopause	_____ yes	_____ no	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature: _____ Date: _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work Phone ( ) _____

Email Address _____ Male_____ Female _____

Social Security # _____ ~~Driver's Lic.#~~ _____ Birthdate _____

Occupation/Employer's Name and address _____

Single____ Married____ Divorced____ Widowed____ Spouse's Occupation/Employer _____

No. of children:____ (In Canada) ~~Health Card#~~ _____ Version Code: _____

Reason for consulting our office? _____

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

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

Adult - (18 to present)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do /did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by _____. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personal, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgement during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Patient's name (*please print*)

_____
Patient's signature

_____
Date

_____
Patient's representative *(If patient is a minor or if physically or mentally impaired)*

_____
Representative's relationship to patient

_____
Translated by

_____
Witness's name

_____
Witness's signature

_____
Date

_____
Witness's signature

_____
Doctor's name

_____
Doctor's signature