Name: ______________________________ Date: ____________________

Injury(ies): Mark or list All injuries. Write the DATE of the injury immediately afterward.

☐Back injury ☐broken bones ☐fall (severe) ☐fracture ☐disability(ies) ☐head injury ☐loss of consciousness ☐joint injury ☐laceration(severe) ☐motor vehicle collision ☐soft tissue injury ☐other_______________

Females only: Mark all that apply below.

I am: ☐Currently pregnant ☐NOT pregnant ☐Unsure

Past Pregnancy History: ☐C-section ☐Vaginal Delivery ☐miscarriage

Insurance Information

Who is responsible for your bill? YOU and … [mark appropriate box(es)] ☐Myself Only ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Other_______________

Insurance carrier: ______________________________ ID#/claim#_________________________

Carrier Phone # _________________________ Adjuster name _________________________

Have you filed an injury report with your employer? ☐Yes ☐No Date:___/___/____ Time:_______am/pm

Lifestyle:

What type of exercise routine do you have?

☐Almost nothing ☐Weight Training ☐Walking ☐Sport ____________ ☐Other ____________

What is your diet and nutrition like?

☐Low-fat diet ☐vegetarian ☐Vegan ☐low carb ☐low cholesterol

☐Diabetic ☐Take supplements ☐Does not take supplements ☐Diet program ____________

What are your habits regarding alcohol, cigarettes, and caffeine?

☐Does not drink ☐Does not smoke ☐Does not drink caffeine

☐Social drinker ☐Social smoker ☐1 cup caffeine per day

☐Light drinker ☐Light smoker ☐More than 5 cups of caffeine per day

☐Moderate drinker ☐Moderate smoker

☐Heavy drinker ☐Heavy smoker

☐Alcoholic

What drugs and medications do you use regularly?

☐Painkillers ☐Anti-depressants ☐Depressants ☐Sleeping Pills

☐Asprin ☐Anti-inflammatory

What are your health goals?

☐Corrective care ☐Relief Care ☐Return to pre-injury status ☐Wellness care ☐Preventative care

☐Increased overall health

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Westenhaver Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Westenhaver Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. A finance charge of 1% per month(12% annually) will be added to any account that is 60days past due. In the even that your account becomes delinquent you become fully responsible for all collection fees and interest charged by the collection agency.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Name_________________________ **Patient Signature**_________________________ **Date:**____________

Consent to treat Minor name: _________________________ **Date:** ____________

Guardian or Spouse's Signature of Authorizing care: _________________________ **Relationship:** ____________

I aknowledge that I have received the Westenhaver Chiropractic Center's notice of Privacy Practices for protected health information.

Patient Name Printed _________________________

Patient Signature _________________________ **Date:** ____________

INFORMED CONSENT FOR CHIROPRACTIC CARE

Every type of health care is associated with some risk of potential problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment.

Soreness- It is common for chiropractic adjustments, traction, massage therapy, physical therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Soft Tissue Injury- Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, therapy, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

Rib Fractures- Rarely a chiropractic adjustment will crack a rib bone. This usually occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those who have osteoporosis on their x-rays.

Disc Herniations- Disk herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Yet, occasionally chiropractic treatment will aggravate the problem.

Stroke- Certain chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA, Vol.37, No.2, June 1993) estimates that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means the average chiropractor would have to be in practice for hundreds of years before he/she would statistically be associated with a single patient stroke.

Other Problems- There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

I understand that I will have an opportunity to discuss with the doctor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interests.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Westenhaver Chiropractic Center. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (printed) ______________________

Patient Signature__________________________ Date Signed ______________

Parent/Guardian Signature____________________ Date Signed______________

Consent for Leaving Messages/Sharing Information with Family/Friends

I understand that my health care information at Westenhaver Chiropractic is protected and I have received a copy of their Notice of Privacy Practices.

In order for Westenhaver Chiropractic to leave detailed messages on my voice mail or answering machine, I need to give permission to Westenhaver Chiropractic.

Consent for leaving messages (Please Check Box)

☐ Yes ☐ No

I consent to information regarding myself (or my child's/under the age of 18) detailed appointment reminders/instructions to be left on my voicemail or answering machine.

Consent for shared Information with family and friends (Please Check Box)

☐ Yes ☐ No

I wish family members or friends to have access to my health care information. The name(s) listed below are family members or friends whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

	Name	Relationship
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________

______________________________ ______________________

Patient Name (Printed) Date of Birth

______________________________ ______________________

Patient/Parent Signature Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.