

Palm Springs

CHIROPRACTIC

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Birthdate: _____

Cell Phone #: _____ Email: _____

Married Single Divorced Partner for _____ Years

Current Work Status: Employed Retired In Between Jobs

Other: _____

Occupation: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

How did you hear about us? _____

Last time you have seen a Chiropractor: _____

Symptoms

What is your main area of concern: _____

When did your problem first start: _____

Specific thing you did that caused the issue? _____

Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling
 Other _____

Circle the severity of your pain: (1 = mild pain/discomfort, to 10 = severe pain)

1 2 3 4 5 6 7 8 9 10
mild severe

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Other

Name and location of any other doctor(s) who have treated you for this condition:

Health History

Check only the conditions that are applicable

- | | | | | | |
|--|--|--|---|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Fractures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> STDS |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gout | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumor/ Growths |

Is there anything else you want us to know?

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays and supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic care at Palm Springs Chiropractic and their support staff who now or in the future treat me while employed by, working or associated with or serving as vacation relief for the doctor(s) of chiropractic, including those working at the clinic or office or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic(s) and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to 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 the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure where what the doctor feels at the time based upon the facts then known is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxers and painkillers, physical therapy, steroid injections, bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the 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 the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:

Date:

(or Patient Guardian/Parent/Representative)

(provide name and relationship if signing for patient)

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Palm Springs Chiropractic.

Please initial one of the following two options below.

1. _____ I wish to receive a paper copy of Privacy Notice
2. _____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial both acknowledgments below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

Cancellation Policy

Due to the high demand and to ensure we can care for others in need of treatment, there will be a 50% charge if not cancelled 24 hours prior to your appointment and a full charge if not cancelled 6 hours prior to your appointment.

We thank you for your understanding.

_____ I agree to the above policy
(Initials)

Patient Name _____

Signature _____

Date _____