Patient Information

Patient Title: Mr. Mrs. Ms.

First Name_____ **Nickname**_____

Last Name_____ **Middle Name**_____

Suffix_____

Address_____ **City**_____

State_____ **Zip Code**_____

Primary Phone_____ **Secondary Phone**_____

Email_____

Best contact method? Primary Phone Home Email

Date of Birth_____ **Age**_____

Gender Male Female Other Rather not say

How did you hear about Serendipity Chiropractic? _____

Do you smoke?Never **Currently** **In the past**

Have you ever had chiropractic care in the past? **Yes** **No**

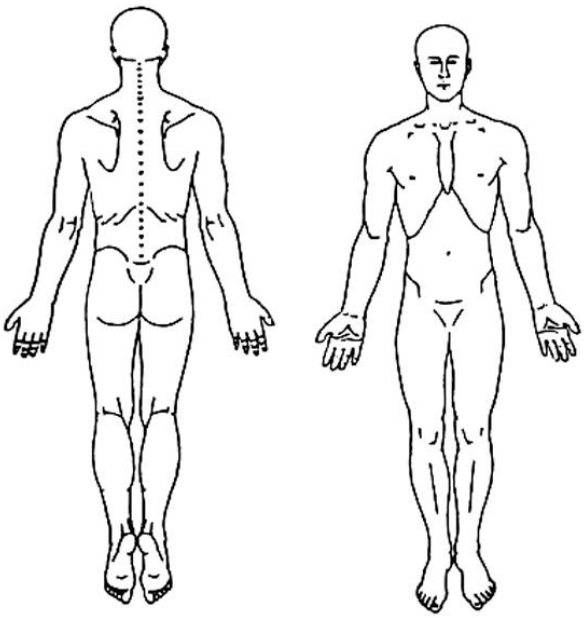
If yes, name and location of chiropractor? _____

What is your occupation? _____

How long have you been working your current job? _____

Current Complaint

What is your main area of complaint? (mark on diagram)



How did your injury happen? _____

_____

Do you have a prior history of same complaint(s)? _____

if so, how was it treated? _____

What makes your pain better? _____

What makes your pain worse? _____

Since it started, has your pain felt: Better Worse The Same

Can you describe the feeling of your pain? Achy sharp sore burning tingling

shooting numb other_____

Does your pain travel to other areas of your body? Where? _____

***When* do you feel your pain most? _____**

How often do you feel your pain? (times per day/week/month/year) _____

From 1-10, 10 being the worst pain imaginable, how would you rate your pain now? _____

At its worse? _____ at its best? _____

How long does your pain last? (seconds/minutes, hours, days, etc.) _____

Does your pain interfere with your activities of daily living? How? _____

_____

Medications/Vitamins/Suppliments

Name	Dosage (if known)	Frequency	Start Date?

While chiropractic treatment is relatively safe, there are contraindications that need to be ruled out before treatment can be administered. Please indicate if you have or have had any of the following:

Circle as many as apply

Spinal surgeries

Stroke

Lack of feeling of entire limbs (upper or lower)

Neurological disorders

Tumors

Spinal cancer

Severe osteoporosis

Cauda equine

Aortic aneurysm

Double vision

Difficulty speaking

Difficulty swallowing

I certify that all the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at Serendipity Chiropractic.

_____ _____

(Signature) (Date)

Informed Consent

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. The majority of patients may notice stiffness or soreness after the first few days of treatment. Rare complications could occur which include fractures, muscular strain, ligament strain, dislocations, or injury to intervertebral discs, nerves or spinal cord. The ancillary procedures could produce skin irritation or minor burns.

Risks of remaining untreated: Delay of treatment allows formation scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

PLEASE do not sign yet until your chiropractor has had a chance to *verbally* re-iterate the informed consent you have just read as well as answer any questions you may have regarding treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

Printed Name	Signature	Date

Financial Agreement

I understand that Serendipity Chiropractic is a *cash only* practice meaning insurance is NOT accepted at this office. The patient is responsible to pay all payments due at the time of service. If the patient fails to pay at the time of service, the doctor reserves the right to deny treatment on further appointments until payment is made. Forms of payments available to follow:

- ✓ Cash
- ✓ Check
- ✓ Credit cards
- ✓ Debit cards
- ✓ HSA/Flex cards

Note: If a check bounces due to insufficient funds, the patient is liable for an extra charge of $25. It is advised to consult the doctor for when the deposit can be made in order to avoid the extra charge. Please sign and date below if you understand and agree to the above statement.

_____ _____

Signature **Date**