Berryville Family Chiropractic

____ ____/____/______

First Name and Middle Initial Last Name Date of Birth

Nickname: ________________________ Gender: Male Female Other

Home Phone: ____________________ Cell Phone: ____________________

Address: ____

Street City State Zip

Mailing Address: ____

(if different from above) Street City State Zip

Email: ____________________________ Occupation: ____________________

Spouse's Name: ____________________ Spouse's Phone: __________________

Emergency Contact (if other than spouse): ________________________

Phone: __________________________ Relationship: _________________

Who may we thank for referring you? ____________________________

Have you been to a Chiropractor before? YES NO

When was your last visit? _____________________________

What is the reason for today's visit?__________________________________

____

<u>Family History</u>- Please circle conditions that any blood relatives have been diagnosed with:

Arthritis High Blood Pressure Stroke Heart Attack

Cancer Diabetes Epilepsy Scoliosis

Would you like us to sign you up for text reminders? YES NO

Phone Number: ________________________

Time: 11AM 4PM 7PM 10PM

(Texts are sent the day before your appointment)

Informed Consent to Treat

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Berryville Family Chiropractic and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back- up providers named below, including those working at this clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Berryville Family Chiropractic provider and/ or office personnel the nature and purpose of these procedures. I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to: muscle spasms for a short period of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Berryville Chiropractic Center provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. It can alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other medical modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are for appointments that are missed or not cancelled within 24 hours of my scheduled time. By my signature at the bottom of this page, I agree to be responsible for all reasonable collection fees and attorney's fees incurred should my account be referred for collection.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Berryville Family Chiropractic.

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, **please read each statement and initial your agreement.**

_________ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_________ I grant permission to be called or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_________ My records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize Berryville Family Chiropractic to release aby information requested by any insurance company, attorney or any doctor that is relative to my examination and treatment. I also authorize the payment of medical benefits directly to Berryville Family Chiropractic.

_________ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the present, severity or cause of my health concern.

Signature ____ Today's Date ___ /___/____

Consultation

Symptoms?

Localized or Radiate?

Accidents, Traumas, or Injuries?

Surgeries?

What makes it better or worse?

Valsalva- Pain when cough or sneeze?

Does it affect your sleep?

Exam

KEMPS:

ELY'S:

JACKSON'S:

NACHLAS:

C- DISTRACTION:

C- COMPRESSION:

LESEAGUE'S:

BRAGGARD'S:

SOTO HALL:

PATRICK FABERE:

LEG LENGTH:

DOCTOR NOTES:

PATIENT HEIGHT:

PATIENT WEIGHT:

FOR OFFICE USE ONLY