

Dynamic Life Chiropractic

CONFIDENTIAL INFORMATION

File # _____

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Hm Phone _____ Cell Phone _____

Email _____

Sex _____ Marital Status _____ Date of Birth _____ Age _____

Children (# _____) Names and ages of Dependant Children _____

SS# _____ Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Spouse Employer _____

Name of Nearest Relative Other Than Spouse _____ Phone _____

Who referred you to our office? _____

Were you referred to a certain doctor in our office? _____

Is your visit due to an injury? No Yes *If yes, circle one:* Auto Work Other _____

(If this visit is due to a work or auto injury, please see the receptionist for a special injury form)

List other doctors you use for your health care: _____

Previous Chiropractor(s): _____

List any surgeries with dates: _____

Note any auto accidents with dates: _____

Insurance Information

Do you have insurance? Yes No Company _____

I.D. # _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Dynamic Life Chiropractic extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Dynamic Life Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient Signature (Or Parent or Guardian): _____ Date _____

INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

There are also potential associated side effects of the chiropractic adjustment, by signing below you acknowledge possible risks and give full informed consent of our chiropractic procedures. Possible associated side effects include: Soreness; a nearly always temporary symptom while your body undergoes therapeutic change. Soft tissue injury; rarely a chiropractic adjustment may injure muscle or ligament structures resulting in a temporary increase in pain. Disc Herniation; occasionally chiropractic adjustments may aggravate a herniated disc, yet this problem occurs so rarely that there are no available statistics to quantify their probability. Stroke; Vertebral Basilar Artery (VBA) stroke is a very rare event in the population (1 in 3 million neck adjustments- Journal of the CCA, Vol. 37 No. 2, June, 1993). The increased risks of VBA stroke are likely due to patients with headache and neck pain from a VBA dissection seeking care before their stroke. Recent research has found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care. (Spine, Vol. 33 No. 45, 2008)

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand
(PRINT NAME)
the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I thereby accept chiropractic care on this basis.

Patient's Signature

Date