



Welcome! Please print clearly and fill in completely

Print Name \_\_\_\_\_ Email \_\_\_\_\_  
Street Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please Check  Sex: Male  Female  Right handed  Left handed  Married  Single

**Health History:**

Give reason for seeking chiropractic care: \_\_\_\_\_

Describe any health problems, including how long you've had them: \_\_\_\_\_

Are you under the care of any other doctor? Yes  No

If Yes, the conditions being treated for \_\_\_\_\_

List any current Medications: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

List any x-rays you've had in the past 2 years: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Work Duties \_\_\_\_\_

**Chiropractic History:**

Have you ever been to a Chiropractor before? Yes  No  If yes, Doctor's

Name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

Date of last chiropractic x-rays \_\_\_\_\_ How long were you under care? \_\_\_\_\_

Are other family members under chiropractic care? Yes  No  Who? \_\_\_\_\_

**Wellness Commitment**

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Where did you hear about our clinic, or who referred you?  
\_\_\_\_\_

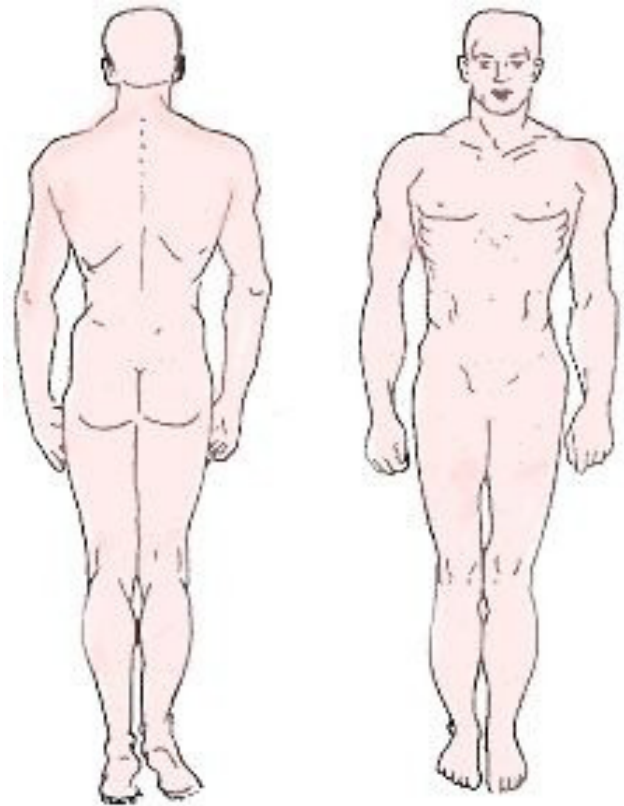
**FEMALES: Please Check One**  Is there a possibility of you being pregnant? **Yes**  **No**

**Please Fill in Below**

**If you have had the following, or if you suffer from the following, Please Check**

**Circle the areas where you have any problems. Please also describe these problems.**

Condition, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>



**Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.**

---



---



---



---



---



---



---



---



---



---

*Thank you for being complete and thorough.*

**Your Signature Below Please**

---

Date: \_\_\_\_\_

## Informed Consent Chiropractic Care with Dr. Fox

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, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. Please feel free to discuss directly with Dr. Fox any questions or concerns you may have.

**Disc Herniation:** Disc herniations are frequently and successfully treated by chiropractors. Occasionally, chiropractic treatment may aggravate the problem, and rarely surgical intervention may become necessary if the chiropractic care is not successful. Very rarely, chiropractic adjustments may also cause a disc problem if the disc is already damaged or in a weakened condition. These problems occur so rarely that there is no available statistical information to quantify their probability.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles, tendons, and ligaments. Rarely, a chiropractic adjustment, traction, massage, etc. may overstretch or tear some muscle, tendon, or ligament fibers. The result is a temporary increase in pain and a brief, temporary increased need for treatment, but in most every case there are no long-term effects to the patient. These problems occur so infrequently and are so rare that there are no available statistics to quantify their probability.

**Rib Fracture:** Rarely, chiropractic adjustment(s) may crack a rib bone. This risk is increased in elderly, osteoporotic bones. We adjust all patients very carefully, especially our elderly patients with osteoporosis. These problems of rib fracture occur so rarely that there are no available statistics to quantify their probability.

**Soreness:** Chiropractic adjustments, traction, massage therapy, exercise, etc. may result in temporary increase in soreness. This is usually a very temporary symptom. It is not dangerous, but please tell Dr. Fox about it.

**Stroke:** Stroke is VERY uncommon, but it is the most serious problems associated with vertebral manipulation of the cervical spine (neck). In the May, 1994 Chiropractic Report, they discuss the problem. **“By any medical standard, chiropractic cervical adjustment is an extremely safe treatment. Vertbral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002% or one case in two million.” In another study, (Journal of CCA, Vol. 37, No. 2, June 1993) they estimate that the risk of this type of stroke is .0003%, one in three million.**

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment, other than those noted above.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment.

Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Personal Medical Information Consent Form

### HIPPA

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations, of our practice. HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

---

Patient Signature

---

Date

#### RESTRICTIONS:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practice. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Brandon D. Fox, D.C. & Staff

## Awareness of Chiropractic Principles

Were you Aware that:

- |   |     |    |
|---|-----|----|
| • Doctors of Chiropractic work with the nervous system?   | YES | NO |
| • The nervous system controls all bodily functions and systems?                                   | YES | NO |
| • If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? | YES | NO |

## Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

\_\_\_\_\_ Relief Care: Symptomatic relief of pain or discomfort

\_\_\_\_\_ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

\_\_\_\_\_ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care

\_\_\_\_\_ I want the Doctor to select the type of care appropriate for my condition.

## About My Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credit to my account upon receipt.

Insurance Name \_\_\_\_\_ Group Number (Plan, Policy #) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_