PROMASSAGE & CHIROPRACTIC
integrative wellness center
A Place For Healing

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# INITIAL INTAKE – MEDICAL QUESTIONAIRE

*Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. These questions will help to identify underlying caused of symptoms and will also assist us to formulate a treatment plan*

## Personal Information

| | |
|---|---|
| **Full name:** | **Date:** |
| **Address:** Street City State Zip | |
| **Home phone:** | **Work phone:** |
| **Cell phone:** | **Email address:** |
| **Best time/place to contact you:** | **SS#** |
| **Date of birth:** **Age:** | **No. of children:** |
| **Any Chance of Pregnancy?** **Yes** ☐ **No** ☐ | **Height:** **Weight:** |
| **Marital status:** **M S W D** | **Spouse/guardian name:** |
| **Occupation:** | **Employer's name & address:** |
| **Name of person responsible for account:** | |
| **Emergency Contact Name:** | **Relationship:** |
| **Phone Number:** | |

**How did you hear about us?** _____ **If-from a client please give us their name so they receive the referral.**

1. Please rank current/ongoing problems by priority and fill in the other boxes as completely as possible:

| Describe top three Health Issues | Rate of severity 1 = mild 10 = worst imaginable | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | % of the time pain or sensation is present |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister

   _____
   _____
   _____

3. Do you have any pets or farm animals? Yes____No_____
   If yes, where do they live? 1._____indoors 2._____Outdoors 3._____Both indoors and outdoors

4. Have you lived or traveled outside of the United States? Yes____No_____
   If so, when and where? _____
   _____

5. Have you or your family recently experienced any major life changes? Yes____No_____
   If yes, please comment: _____
   _____

6. Have you experienced any major losses in life? Yes____No_____
   If so, please comment: _____
   _____

7. Have you experienced any emotional or physical trauma/abuse in your lifetime? Yes____No_____
   _____
   _____
   _____

8. How important is religion or spirituality for you and your family's life?
   a. _____ not at all important
   b. _____ somewhat important
   c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days
   b. _____ 3 –14 days
   c. _____ > 15 days

10. Past Medical and Surgical History:

| | ILLNESSES | WHEN | COMMENTS |
|---|---|---|---|
| | Anemia | | |
| | Arthritis | | |
| | Asthma | | |
| | Autoimmune Disorder | | |
| | Breast (Fibrocystic, Calcifications, Densities) | | |
| | Bronchitis/Emphysema/Pneumonia | | |
| | Cancer | | |
| | Clotting Defects | | |
| | Childhood Illness (i.e. rheumatic fever, chickenpox, mumps, measles, etc.) | | |
| | Chronic Fatigue Syndrome | | |
| . | Crohn's Disease or Ulcerative Colitis | | |
| | Dental Issues | | |
| | Depression/Anxiety | | |
| | Diabetes (Type 1, Type 2) | | |
| | Eating Disorder (Anorexia, Bulimia) | | |

| | | |
|---|---|---|
| Epilepsy, convulsions, or seizures | | |
| Fibromyalgia | | |
| Gallstones | | |
| Gout | | |
| Heart Disease, Attack/Angina/Failure | | |
| High blood fats (cholesterol, triglycerides) | | |
| High blood pressure (hypertension) | | |
| Irritable bowel | | |
| Kidney stones | | |
| Liver Disease (Hepatitis, Fatty, Other) | | |
| Osteoporosis/Osteopenia | | |
| Sinusitis | | |
| Sleep apnea | | |
| Stroke | | |
| Thyroid disease | | |
| Other (describe) | | |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury | | |
| Fracture / Right or Left | | |
| Head injury | | |
| Neck injury | | |
| Other (describe) | | |
| **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
| Barium Enema | | |
| Bone Scan | | |
| CAT Scan (Location) | | |
| Chest X-ray | | |
| Colonoscopy/Sigmoidoscopy | | |
| EKG | | |
| MRI | | |
| Thermogram | | |
| Upper GI Series | | |
| Other (describe) | | |

| OPERATIONS | WHEN | COMMENTS |
|---|---|---|
| Appendectomy | | |
| Cosmetic Surgery (Location) | | |
| Dental Surgery | | |
| Gall Bladder | | |
| Hernia | | |
| Hysterectomy (Partial or Total) | | |
| Tonsillectomy | | |
| Tubal Ligation | | |
| Vasectomy | | |
| Other (describe) | | |

11. Hospitalizations:

| WHERE HOSPITALIZED | WHEN | FOR WHAT REASON |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |
| e. | | |

12. How often have you have taken antibiotics?

| | < 5 times | > 5 times |
|---|---|---|
| Infancy/ Childhood | | |
| Teen | | |
| Adulthood | | |

13. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

| | < 5 times | > 5 times |
|---|---|---|
| Infancy/ Childhood | | |
| Teen | | |
| Adulthood | | |

14. Are you allergic to any medications? Yes _____ No _____
If yes, please list with reactions:

_____

_____

_____

15. What medications are you taking now? Include non-prescription drugs.

| Medication Name/Dose | Date started | Tolerance/Side Effects |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

16. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

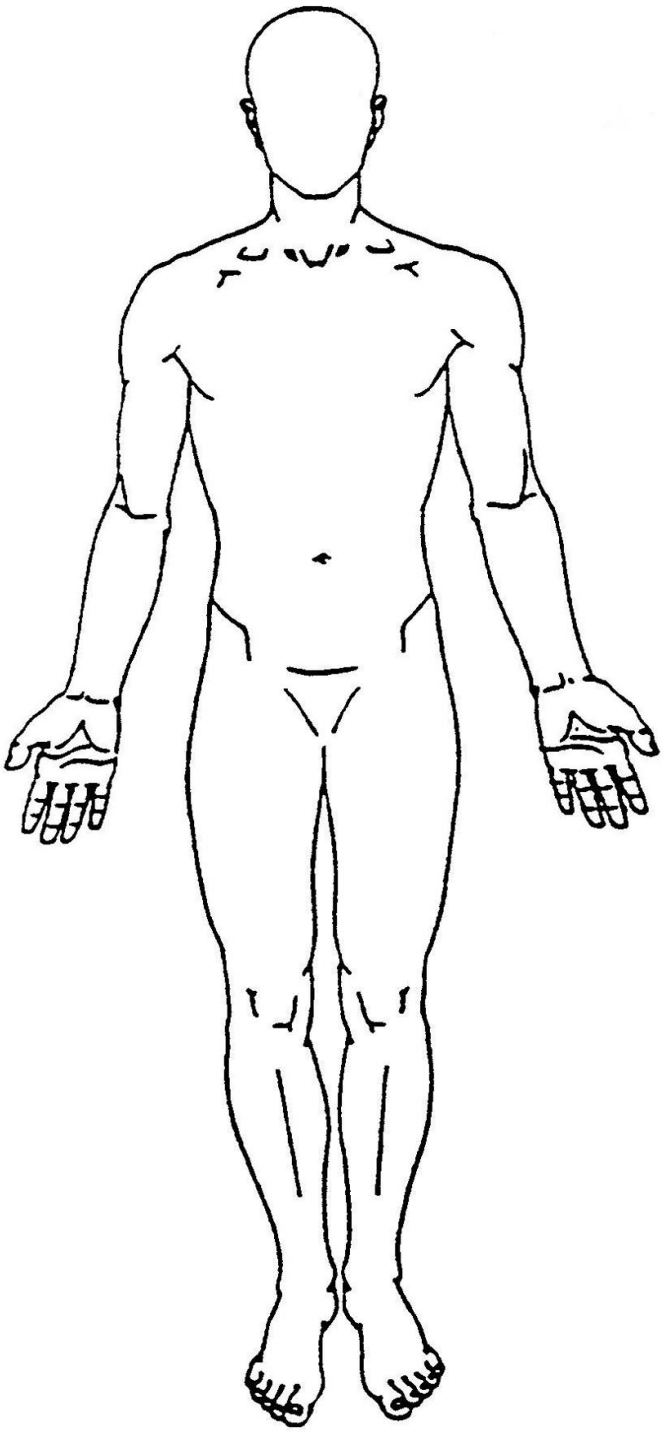
| Supplement Name, Dose and Brand | Date started | Effective? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

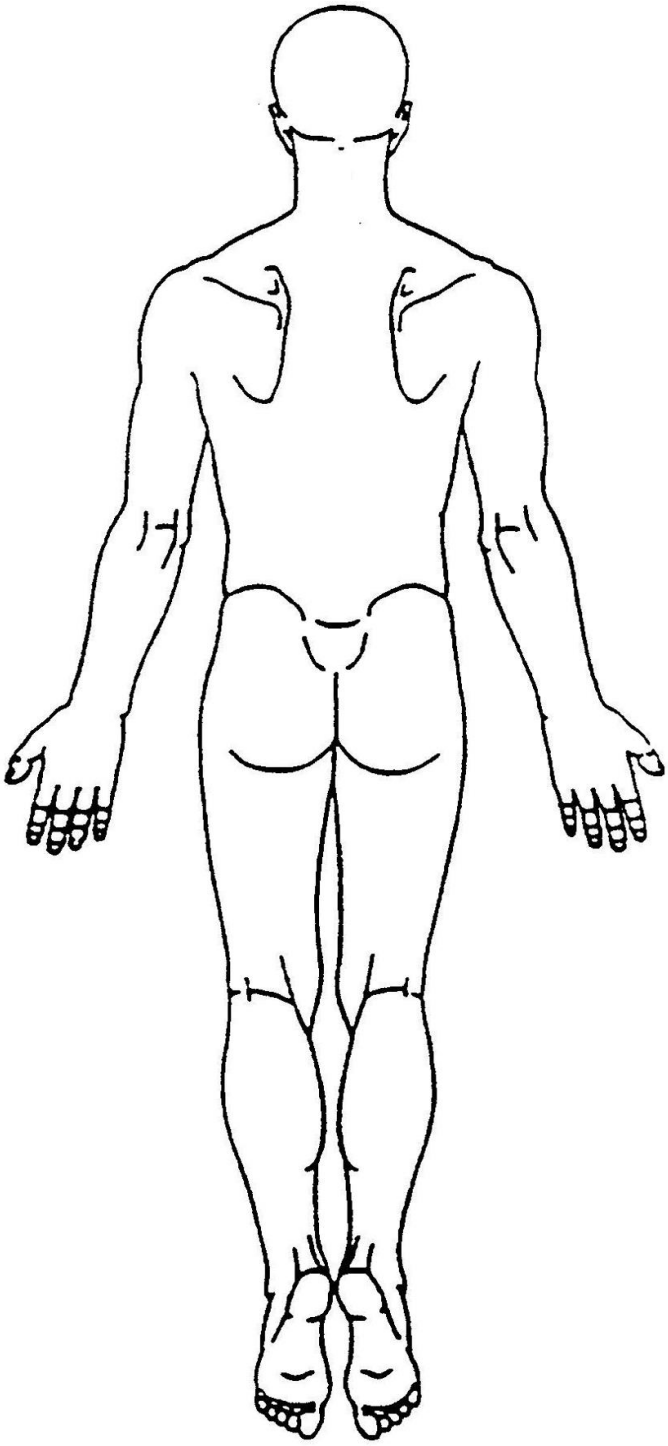
# PAIN DRAWING

**Patient Name** _____**Date**_____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas.

**A** = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing





17. Childhood:

| Question | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| 1. Were you a full term baby? | | | | |
| a. A preemie? | | | | |
| b. Breast fed? | | | | |
| c. Bottle fed? | | | | |
| 2. As a child did you eat a lot of sugar and/or candy? | | | | |

18. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____
_____

19. Are you on a special diet? Yes____No___ How long have you been on this diet?_____
_____ GFCF _____vegetarian _____other (describe):
_____ Diabetic _____vegan _____
_____ Dairy restricted _____blood type diet _____

20. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

21. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

22. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____No_____

23. Do you feel much **worse** when you eat a lot of :
_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

24. Do you feel much **better** when you eat a lot of :
_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

_____

No____
_____

25. How well have things been going for you?

| | Very Well | Fair | Poorly | Very Poorly | Does not apply |
|---|---|---|---|---|---|
| a. At school | | | | | |
| b. In your job | | | | | |
| c. In your social life | | | | | |
| d. With close friends | | | | | |
| e. With sex | | | | | |
| f. With your attitude | | | | | |
| g. With your boyfriend/girlfriend | | | | | |
| h. With your children | | | | | |
| i. With your parents | | | | | |
| j. With your spouse | | | | | |

26. Have you ever had psychotherapy or counseling? Yes____No_____
Currently?_____ Previously?_____If previously, from_____to_____.
What kind? _____
Comments: _____

27. Are you currently, or have you ever been, married? Yes____No_____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never_
When were you divorced? _____ Never_
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

28. Hobbies and leisure activities: _____
_____

29. Do you exercise regularly? Yes____No_____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____<15 min
2._____16-30 min
3._____31-45 min
4._____> 45 min

What type of exercise is it?
_____Jogging/walking
_____Basketball
_____Home aerobics
_____tennis
_____water sports
_____other _____

**50. FAMILY HISTORY:** For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health, and
2. Any illnesses they have had.

| *(Note: Except for **spouse** , Family refers to **blood** or **natural** relatives.)* **PRINT NAME/AGE BELOW** | Good Health | Poor Health | Deceased/ Cause | Alcoholism | Allergies or Asthma | Alzheimer's or Dementia | Anemia | Blood Clotting Problems | Diabetes | Cancer or Tumor | Epilepsy | Genetic Disease | Heart Trouble | High Blood Pressure | Kidney or Bladder Dis. | Nervous Breakdown | Rheumatism or Arthritis | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Father** | | | | | | | | | | | | | | | | | | |
| **Mother:** | | | | | | | | | | | | | | | | | | |
| **Brothers/Sisters:** | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Spouse:** | | | | | | | | | | | | | | | | | | |
| **Child:** | | | | | | | | | | | | | | | | | | |
| **Child:** | | | | | | | | | | | | | | | | | | |
| **Child:** | | | | | | | | | | | | | | | | | | |
| **Child:** | | | | | | | | | | | | | | | | | | |
| **Paternal relatives** (in each box, write in how many affected with condition): | | | | | | | | | | | | | | | | | | |
| **Maternal relatives** (in each box, write in how many affected with condition): | | | | | | | | | | | | | | | | | | |

30. Any other family history we should know about? Yes____No_____
    If so, please comment: _____

31. What is the attitude of those close to you about your illness?
    _____Supportive
    _____Non-supportive

**32. Please check if these symptoms occur presently or have occurred in the past 6 months. Note location where applicable.**

| GENERAL: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Cold hands & feet | | | |
| Cold intolerance | | | |
| Daytime sleepiness | | | |
| Difficulty falling asleep | | | |
| Fatigue (AM/PM/Constant) | | | |
| Fever | | | |
| Flushing | | | |
| Heat intolerance | | | |
| Insomnia | | | |
| Nightmares | | | |
| No dream recall | | | |
| Weight Gain/Loss | | | |
| **HEAD, EYES & EARS:** | | | |
| Conjunctivitis | | | |
| Distorted sense of smell | | | |
| Distorted taste | | | |
| Ear fullness | | | |
| Ear noises | | | |
| Ear pain | | | |
| Ear ringing/buzzing | | | |
| Eye dryness/crusting | | | |
| Eye pain | | | |
| Eyelid margin redness | | | |
| Headache (Migraine or Tension) | | | |
| Hearing loss | | | |
| Hearing problems | | | |
| Migraine | | | |
| Sensitivity to loud noises | | | |
| Vision problems | | | |

| MUSCULOSKELETAL: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Back muscle spasm | | | |
| Calf cramps | | | |
| Chest tightness | | | |
| Foot cramps | | | |
| Joint deformity | | | |
| Joint pain / redness | | | |
| Joint stiffness | | | |
| Muscle pain | | | |
| Muscle spasms | | | |
| Muscle stiffness | | | |
| Muscle twitches: Around eyes | | | |
| Arms or legs | | | |
| Muscle weakness | | | |
| Tendonitis | | | |
| Tension headache | | | |
| TMJ problems | | | |
| **MOOD/NERVES:** | | | |
| Agoraphobia | | | |
| Anxiety / panic attacks | | | |
| Auditory hallucinations | | | |
| Black-out | | | |
| Depression / Low Mood | | | |
| Difficulty: Concentrating | | | |
| With balance | | | |
| With thinking | | | |
| With judgment | | | |
| With speech | | | |
| With memory | | | |
| Dizziness (spinning) | | | |
| Fainting | | | |
| Fearfulness | | | |
| Irritability | | | |
| Light-headed | | | |

| MOOD/NERVES, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Mood swings | | | |
| Numbness /Tingling | | | |
| Obsessive / compulsive | | | |
| Other Phobias | | | |
| Paranoia | | | |
| Seizures | | | |
| Suicidal thoughts/Plan | | | |
| Tremor/trembling | | | |
| Visual hallucinations | | | |
| **EATING:** | | | |
| Binge eating | | | |
| Bulimia | | | |
| Can't gain weight | | | |
| Can't lose weight | | | |
| Carbohydrate craving | | | |
| Carbohydrate intolerance | | | |
| Poor appetite | | | |
| **DIGESTION:** | | | |
| Anal spasms | | | |
| Bad teeth | | | |
| Bleeding gums | | | |
| Bloating | | | |
| Blood in stools | | | |
| Burping / belching | | | |
| Canker sores | | | |
| Cold sores | | | |
| Constipation | | | |
| Cracking at corner of lips | | | |
| Dentures w/poor chewing | | | |
| Diarrhea | | | |
| Difficulty swallowing | | | |
| Dry mouth | | | |
| Feels full too long after meal | | | |
| Farting | | | |

| DIGESTION, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Fissures | | | |
| Heartburn/Reflux | | | |
| Hemorrhoids | | | |
| Intolerance to: Lactose | | | |
| All milk products | | | |
| Intolerance to: Gluten (wheat) | | | |
| Corn | | | |
| Eggs | | | |
| Fatty foods | | | |
| Yeast | | | |
| Liver disease/jaundice (yellow eyes or skin) | | | |
| Lower abdominal pain | | | |
| Mucus in stools | | | |
| Nausea | | | |
| Periodontal disease | | | |
| Sore tongue | | | |
| Stomach pain | | | |
| Strong stool odor | | | |
| Undigested food in stools | | | |
| Upper abdominal pain | | | |
| Vomiting | | | |
| **SKIN PROBLEMS:** | | | |
| Acne on back | | | |
| Acne on chest | | | |
| Acne on face | | | |
| Acne on shoulders | | | |
| Athlete's foot | | | |
| Bumps on back of upper arms | | | |
| Cellulite | | | |
| Dark circles under eyes | | | |
| Ears get red | | | |
| Easy bruising | | | |

| SKIN PROBLEMS, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Eczema | | | |
| Hair Loss | | | |
| Herpes - genital | | | |
| Hives | | | |
| Jock itch | | | |
| Lackluster skin | | | |
| Mole w color/size change | | | |
| Oily skin | | | |
| Pale skin | | | |
| Patchy dullness | | | |
| Psoriasis | | | |
| Rash | | | |
| Red face | | | |
| Sensitive to bites | | | |
| Sensitive to poison ivy/oak | | | |
| Shingles | | | |
| Skin cancer | | | |
| Skin darkening | | | |
| Strong body odor | | | |
| Thick calluses | | | |
| Vitiligo | | | |
| **SKIN, ITCHING:** | | | |
| Anus | | | |
| Arms | | | |
| Ear canals | | | |
| Eyes | | | |
| Feet | | | |
| Hands | | | |
| Legs | | | |
| Nipples | | | |
| Nose | | | |
| Penis | | | |
| Roof of mouth | | | |
| Scalp | | | |
| Skin in general | | | |
| Throat | | | |
| Wheezing | | | |

| SKIN, DRYNESS OF: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Feet cracking /peeling | | | |
| Hair dry/loss | | | |
| Hands cracking /peeling | | | |
| Mouth/throat | | | |
| Scalp dandruff | | | |
| Other | | | |
| **LYMPH NODES:** | | | |
| Neck enlarged/tender | | | |
| Other enlarged/tender lymph nodes | | | |
| **NAILS:** | | | |
| Bitten | | | |
| Brittle / soft | | | |
| Curve up / frayed | | | |
| Fungus - fingers / toes | | | |
| Pitting / ridges | | | |
| Ragged cuticles | | | |
| Thickening of: Finger nails / toenails | | | |
| White spots/lines | | | |

| RESPIRATORY: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Bad breath | | | |
| Bad odor in nose | | | |
| Cough - dry / productive | | | |
| Hay fever: Season_____ | | | |
| Hoarseness | | | |
| Nasal / Sinus stuffiness | | | |
| Nose bleeds | | | |
| Post nasal drip | | | |
| Shortness of breath | | | |
| Sinus infection | | | |
| Snoring | | | |
| Sore throat | | | |

| **CARDIOVASCULAR:** | | | |
|---|---|---|---|
| Angina/chest pain | | | |
| Breathlessness | | | |
| Heart attack | | | |
| Heart murmur | | | |
| High/low blood pressure | | | |
| Mitral valve prolapse | | | |
| Palpitations/Irregular Pulse | | | |
| Phlebitis | | | |
| Rapid Heart Rate /Tachycardia | | | |
| Swollen ankles/feet /hands | | | |
| Varicose veins | | | |

| **URINARY:** | **Mild** | **Mod-erate** | **Severe** |
|---|---|---|---|
| Bed wetting | | | |
| Blood in urine | | | |
| Hesitancy /urgency | | | |
| Bladder Infection | | | |
| Kidney disease / stones | | | |
| Leaking/incontinence | | | |
| Nocturia (# times per night _____) | | | |
| Pain/burning | | | |
| Prostate enlargement | | | |
| Prostate infection | | | |
| PSA Level Normal? | | | |
| **MALE REPRODUCTIVE:** | | | |
| Discharge from penis | | | |
| Ejaculation problem | | | |
| Genital pain | | | |
| Erectile dysfunction /maintaining erections | | | |
| AM Erections? | | | |
| Infection | | | |
| Lumps in testicles | | | |
| Poor libido (sex drive) | | | |

| **FEMALE REPRODUCTIVE:** | | | |
|---|---|---|---|
| Breast cysts / lumps | | | |
| Breast tenderness | | | |
| Ovarian cyst | | | |
| Poor libido (sex drive) | | | |
| Endometriosis | | | |
| Fibroids | | | |
| Hot Flashes/Night Sweats | | | |
| Infertility | | | |
| Nipple discharge | | | |
| Painful intercourse | | | |
| Vaginal discharge | | | |
| Vaginal dryness | | | |
| Vaginal odor / itch | | | |
| Vaginal pain | | | |
| <u>Premenstrual:</u> Bloating | | | |
| Breast tenderness | | | |
| Carbohydrate craving | | | |
| Chocolate craving | | | |
| Constipation | | | |
| Decreased sleep | | | |
| Diarrhea | | | |
| Fatigue | | | |
| Increased sleep | | | |
| Irritability | | | |
| <u>Menstrual</u>: Cramps | | | |
| Heavy periods | | | |
| Irregular periods | | | |
| No periods | | | |
| Scanty periods | | | |
| Spotting between | | | |

# Frequency Specific Microcurrent Consent

I,_____ authorize the Promassage & Chiropractic to perform the treatment known as Frequency Specific Microcurrent therapy(FSM). This is a noninvasive means of treating various conditions, including chronic pain. Your practitioner may recommend this treatment for off label uses of this device as there have been studies evolving in the literature supporting new uses. The equipment that we use is classified by the FDA as a TENS unit/device. TENS has not been shown to have any short- or long-term complications to date. However, the possibility that the device may affect some sensitive users in a presently unknown way cannot be overlooked. I understand that FSM involves the use of physiologic (tiny) amounts of electric current (ie. Millionths of an ampere) applied to the body. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. However, I recognize that the chances of success are enhanced by following the directives of my clinician (for example, to be well hydrated on the day of my treatment). There are some people who may not be able to receive FSM therapy, including women who are pregnant and patients using demand type pacemakers. ***Please initial the following statements below:***

_____I am not pregnant,
_____I do not have demand style pacemaker, or any other implanted electronic device that cannot be turned off
_____I do not have any infections.
_____I do not have seizures or epilepsy

I recognize that FSM therapy has potential risks and potential benefits. These risks and benefits are as follows: Potential Risks: FSM has a history of safety and side effects are uncommon. If they do arise, they typically start during or about 90 minutes after treatment and last for a few minutes to a few hours. Side effects are similar to any use of electrical media when applied to the body, such as Ultrasound, EKG, etc., or to having a massage. These include irritation at the site of stimulation, soreness, fatigue, light-headedness, drowsiness or transient weakness. Symptoms may also worsen transiently before improving. Some treatments can result in transient dizziness. Microcurrent/TENS can induce seizures if there is a history of epilepsy.

**Potential Benefits:** Microcurrent therapy is painless, often increases speed of recovery, and often promotes healing in conditions that have not responded to other treatment. Microcurrent therapy can also lead to resolution of the health concern being treated and the inducement of a greater sense of well-being. The effects are long lasting and occur without the side effects of pharmaceutical drugs. I hereby release Promassage & Chiropractic from all liability in connection with the FSM therapy I receive. I understand that I am free to discontinue treatment at any time.

I understand this consent form and have had any questions answered by my practitioner.

_____

Patient Name Printed

_____ _____

Patient Signature Date

## Informed Consent for Chiropractic Care/Massage Therapy

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-Rays, on me (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Pro Massage & Chiropractic or any doctor, who now or in the future, that works as a relief doctor. I also consent to modalities being done by licensed CTA's and massage therapy being done by licensed LMT's.
I understand I may receive massage therapy as part of my treatment plan. In regards to massage therapy I understand I have the following rights and responsibilities:

- I have the right to control the amount of pressure applied.
- I have the right to my comfort in the area of temperature, music, lighting, table positioning and draping technique for my highest comfort level.
- I have the right to talk or not to talk, share or not share about my internal experiences.
- I have the right to be treated with respect and without judgment: physically, emotionally, and spiritually.
- I have the right to experience safety and comfort in respect to areas of the body touched, amount of clothing worn/removed and draping techniques used.
- If the session includes the removal of any clothing, I have the right to dress and undress in privacy.

Client responsibilities:
I will let my practitioner know of all relevant medical issues prior to the start of our session. I agree to let my practitioner know if touch in any area is uncomfortable or needs to be modified for my comfort.

I understand that the touch or manner of communication of the licensed massage therapist is never intended to be sexual in nature. If at any time, I feel the touch, manner or language of the therapist is inappropriate for me, I will immediately inform the practitioner. Inappropriate behavior advances, or language towards the practitioner are grounds for termination of the session resulting in full payment for the session.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also 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, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

**Cancelation Policy: I understand that I must provide a minimum of 24 hours' notice to cancel or change an appointment. Failure to abide by this policy will result in a charge equal to half of the appointment fee being applied to the credit card we have on file or being applied to your account.**

**There are no refunds on gift cards or packages/series that are bought.**

I have read, or have had read to me, the above consent. I have 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) for which I seek treatment.

**I have completed this health form to the best of my knowledge.**

Patient Name_____

Signature_____Date_____

Reviewed by: _____on:_____

Tel: (615) 448-6446
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Goodlettsville, TN 37072
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# ACKNOWLEDGEMENT OF RECEIPT OF

# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Printed Patient Name (please print neatly) Date

_____
Parent, Guardian or Patient's legal representative

_____
Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

_____ _____