Name _____ Date _____

Address _____

City _____ State_____ Zip _____

Sex ◯ Female ◯ Male Birthdate_____

Preferred Phone (_____)_____ Email _____

◯ Married ◯ Widowed ◯ Single ◯ Divorced ◯ Partnered for _____ Years

Patient Employed/School_____ Occupation _____

Emergency Contact _____ Phone (_____)_____

Whom may we thank for referring you to us? _____

Symptoms

Reason for visit? _____ Symptoms started? _____

Where specifically is the problem(s) located? _____

Is the condition getting progressively worse, better, same? _____

Is the pain constant or intermittent? _____

Type of pain

◯ Sharp ◯ Dull ◯ Throbbing ◯ Numbness ◯ Aching ◯ Shooting ◯ Burning
◯ Tingling ◯ Cramps ◯ Stiffness ◯ Swelling ◯ Other

Rate the severity of your pain: (1 = mild pain/discomfort, to 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

What treatment have you already received for your condition?

◯ Medication ◯ Surgery ◯ Physical Therapy ◯ Other

Name and location of any other doctor(s) who have treated you for this condition:

_____

Healthy History

Check only the conditions that are applicable

◯ Aids/HIV
◯ Alcoholism
◯ Allergy Shots
◯ Anemia
◯ Anorexia
◯ Arthritis
◯ Bleeding Disorder
◯ Breast Lump
◯ Bronchitis
◯ Bulimia
◯ Cancer
◯ Cataracts
◯ Chemical Dependency
◯ Chicken Pox
◯ Diabetes
◯ Emphysema
◯ Epilepsy
◯ Fractures
◯ Glaucoma
◯ Goiter
◯ Gout
◯ Heart Disease
◯ Hepatitis
◯ Hernia
◯ Herniated Disc
◯ High Cholesterol
◯ Kidney Disease
◯ Liver Disease
◯ Measles
◯ Miscarriage
◯ Multiple Sclerosis
◯ Osteoporosis
◯ Pacemaker
◯ Parkinson's Disease
◯ Pinched Nerve
◯ Pneumonia
◯ Polio
◯ Prostate Problem
◯ Prosthesis
◯ Psychiatric Care
◯ Rheumatoid Arthritis
◯ STDs
◯ Stroke
◯ Suicide Attempt
◯ Thyroid Problems
◯ Tonsillitis
◯ Tuberculosis
◯ Tumor/Growths

Is there anything else you want us to know?

_____

_____

_____

_____

Chiropractic informed consent to treat

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 and supportive therapies on me~~ (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic care indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I further 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 and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure where what the doctor feels at the time based upon the facts then known is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxers and painkillers, physical therapy, steroid injections, bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the 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.

Patient Signature:	Date:
(or Patient Guardian/ Parent/ Representative)	(provide name and relationship if signing for patient)

Exponential
CHIROPRACTIC HEALING CENTER
103 College Ave N, St Joseph MN 56374 Phone # 320-363-4573

The following therapy MAY be recommended for your condition. Typically, this therapy may not be covered by insurance, or if billed to insurance, would cost you more out of pocket than our cash rate.

Please let us know if you have any questions.

____Ultrasound $25

____PhotoTherapy $25

____Graston $15

____Spinal Decompression $60

Payments are due at time of service.

I understand that I am responsible for the charges above.

_____ _____

Patient name Date