**Today's Date** _____

**Birth Date (MM/DD/YYYY)** _____

**Gender**
☐ Male ☐ Female

**Last Name** _____

**First Name** _____ **Preferred Name** _____

**Marital Status**
☐ Single ☐ Married
☐ Divorced ☐ Separated
☐ Widowed

**Address** _____

**City** _____ **State** _____ **ZIP/Postal Code** _____

**Cell Phone** _____ **Carrier – (AT&T/Verizon/Etc.)** _____ **Alt. Phone** _____

**E-Mail Address** _____

**Emergency Contact** _____ **Phone** _____

**Your Occupation** _____ **Your Employer** _____

**Primary Physician** _____

**May we share our results with them?**
◯ **Yes** ◯ **No**

**Have you had chiropractic care before?** ◯ **Yes** ◯ **No** **What was the result?** _____

**How did you hear about us?** _____

**List any major medical treatment you've had in the past year:** _____

_____

**Auto Accident**

Is your condition due to Automobile Accident? ☐ Yes ☐ No Date of accident _____
Auto Accident Insurance Name _____ Claim # _____
Adjuster Name _____ Phone # _____
Attorney Name _____ Phone # _____

**Workers Compensation**

Is your condition due to an Employment Related Injury? ☐ Yes ☐ No Have you reported it? ☐ Yes ☐ No
Date of accident _____
Supervisor _____ Supervisor's Phone # _____

## SEE REVERSE SIDE

# WHOLE BODY HEALTH CARE

Our office provides a broad range of service: The procedures are described for you below. Please read through and if you have any questions or concerns ask/tell one of our staff.

### ORTHOPEDIC EVALUATION

This is a Western Diagnostic procedure. It includes palpation or touching as well as standard tests to evaluate the nerves, muscles, ligaments, bones and joints of the body.

### X-RAYS

X-rays are not standard procedure in this office.

### HOME REHABILITATION EXERCISES

These are recommended to all patients to strengthen and improve your health at home. Generally, they include posture as well as specific exercises for your case.

### DIAGNOSTIC MASSAGE

An evaluation of spasms, tenderness, swelling, scar tissue, deformities, etc. Since the nervous system controls the function of the whole body, all patients get a spinal massage from head to tailbone. Therefore, men disrobe from the waist up and women put on a gown. Some patients are requested to put on shorts for better accessibility to lower body injures application of therapies.

### HYDE PARK FITNESS MEMBERSHIP $IO/MONTH

Discounted memberships are available for patients that are current in the office. There is a $10 one-time charge to get 24-hour card.

### HOMEOPATHIC INJECTIONS WITH OZONE & PRP

For soft tissue, arthritis, and nerve repair. All are done subcutaneous or intramuscular to improve healing.

### CHIROPRACTIC MANIPULATION

Many forms of chiropractic manipulations are performed on all joints of the body. This includes the standard manual distraction, Diversified, Cox traction, Activator, Thompson drop, or passively mobilizing joints.

### ACUPUNCTURE

This is based on restoration of the body's natural healing energy and can heal the body's injuries many times faster. The power to restore this energy is stimulated by placing small, sterile needles into points along pathways called meridians. There are fourteen known meridian pathways that are connected to the body's organs and the pathways travel up & down the entire body. Where to place the needles depends on several tests: 1) History 2) Feeling pulse 3) Looking at the tongue 4) Association point tenderness, tested during diagnostic massage 5) Alarm point diagnosis, 13 points located on the chest and abdominal wall. These points are lightly touched, looking for tenderness while muscle testing.

### THERAPY MODALITIES

These are commonly used in physical therapist offices and we also provide them with your treatment.

I hereby authorize any affiliated providers with this office to administer treatment they deem necessary in my case. I do hereby give my consent for the performance of conservative non-surgical treatment used in this office. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge.

**To the best of my ability, the information I have supplied is complete and truthful.**

Patient's Name _____

Signature _____ Date _____

**CONSENT TO TREAT A MINOR**

It is the understanding that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. I realize full responsibility for all charges and payments due rests upon me.

Parent / Guardian / Custodian Signature _____ Date _____

**SEE REVERSE SIDE**