CONFIDENTIAL PATIENT INFORMATION

Patient ID #: _____

Phone: _____

Name _____ Email: _____

Address _____ Apartment _____

City _____ State _____ Zip Code _____ Gender Male _____ Female _____

Age _____ Date of Birth _____ Marital Status: M S W D How many children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone _____

Emergency Contact _____ Phone _____

Referred By: _____

Date of Last Physical Examination _____

What Operations Have You Had? _____ When? _____

Serious Illnesses? _____ When? _____

Have You Ever Suffered From:

1. Dizziness: _____
2. Backaches: _____
3. Heart Trouble: _____
4. Diabetes: _____
5. Tuberculosis: _____
6. Arthritis: _____
7. Headaches: _____
8. Numbness: _____
9. Asthma: _____
10. Neuritis: _____
11. Digestive Disorders: _____
12. Nervousness: _____
13. Sinus Trouble: _____
14. Anemia: _____
15. Rheumatic Fever: _____
16. Cancer: _____

Purpose of this appointment: _____

Other Doctors Seen For This Condition _____

Have you been treated for any health condition by a physician in the last year? YES ☐ NO ☐

Describe _____

What medications or drugs are you taking? _____

Remarks and additional information _____

_____

Opt in for Email Updates/Reminders YES ☐ NO ☐ Opt in for Text Reminders YES ☐ NO ☐

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Dr. Christopher R. Young* 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 *Dr. Christopher R. Young* will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care: _____ Date: _____

Information Taken By: _____ Date: _____

Welcome to our office!

OUR MISSION IS TO PROVIDE THE HIGHEST QUALITY AND AFFORDABLE CHIROPRACTIC CARE. WITH DEDICATION, WE PROMOTE A BETTER QUALITY OF LIFE.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: *to locate, analyze, and correct spinal interference to the nervous system (nerve pressure).* The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (*spinal misalignment producing nerve interference)*, in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

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 below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing 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 of clinic personnel the nature and purpose of chiropractic adjustment and procedures. I understand that results are not guaranteed.

I 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 risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that is known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the 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, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

Patient's Signature: _____ **Date:** _____

Guardian/Spouse's Signature: _____ **Date:** _____

Indicate relationship to patient:_____

FEMALES ONLY

Are you pregnant? Y N

If x-rays are recommended, your signature is required (below) to indicate that you are NOT pregnant.

Signature: _____ Date: _____

CANCELLATION POLICY

We know your time is valuable, and ours is too. Out of respect for our staff and our other patients, we ask that you give us at least 24 hour notice, by calling or using the online booking system, if you need to cancel/reschedule an appointment.

The first time a patient misses an appointment, we will make a note in your file. All future missed appointments will incur a 50% fee or loss of follow-up appointment.

If you are more than 10 minutes late to an appointment we may need to reschedule your appointment.

We ask that you provide us with a credit card to keep on file. However, we will not charge it without notification.

Please sign below to confirm acknowledgement of policy:

Name: _____

Signature: _____

Date: _____

Thank you from our office!