

**INSTRUCTIONS: Please Print**

TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL #: (\_\_\_\_) \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ SEX: \_\_\_\_ MARITAL STATUS: S M D W # OF CHILDREN \_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ MI \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

REFERRED BY: Friend/Relative Newspaper Yellow Pages Sign Other \_\_\_\_\_

Which one of our patients may we thank for referring you? \_\_\_\_\_

I am seeking help for (please circle all that apply):

- |                       |                   |                         |                |                              |                   |
|-----------------------|-------------------|-------------------------|----------------|------------------------------|-------------------|
| 01) Sinus             | 08) Migraines     | 15) Hand/Wrist Pain     | 22) Foot Pain  | 29) Low Back Pain            | 36) Weak Immunity |
| 02) Hip Pain          | 09) Jaw - TMJ     | 16) Neck Pain           | 23) Numbness   | 30) Mid Back Pain            | 37) Infertility   |
| 03) Chest Pain        | 10) Asthma        | 17) Neck Stiffness      | 24) Digestion  | 31) Upper Back Pain          | 38) Depression    |
| 04) Allergies         | 11) Arthritis     | 18) Tailbone Pain       | 25) Headaches  | 32) Menstrual problems       |                   |
| 05) Arm Pain          | 12) Sciatica      | 19) General Health      | 26) Bedwetting | 33) Fibromyalgia             |                   |
| 06) Knee Pain         | 13) Ulcers        | 20) Nervousness/tension | 27) Leg Pain   | 34) Chronic Fatigue Syndrome |                   |
| 07) Chronic Infection | 14) Shoulder Pain | 21) Ankle Pain          | 28) Elbow Pain | 35) Other: _____             |                   |

Other Complaints (please specify): \_\_\_\_\_

**My condition is due to (please circle):**

- |                      |                      |             |
|----------------------|----------------------|-------------|
| 01) Auto Accident    | 03) Sports Accident  | 05) Unknown |
| 02) Accident at Work | 04) Accident at Home | 06) Other   |

**I Desire (please circle): 1) Maximum Improvement 2) Temporary Relief**

Have you ever had spinal surgery? (No) (Yes) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Medical Doctor: \_\_\_\_\_

When was your last medical physical (approximate date)?: \_\_\_\_/\_\_\_\_/\_\_\_\_

How long has it been since your last Chiropractic adjustment? \_\_\_\_\_

I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that I am responsible for any/all legal costs associated with the collection process. I authorize the release of any personal / medical information to McCormack Chiropractic S.C. to collect or settle any outstanding bills for a period of seven years.

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him/her of any consequence thereof. I authorize any outside medical exam report/ review to be released to McCormack Chiropractic S.C. upon their request.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photocopy of this agreement shall serve as the original. I acknowledge I have been offered a copy of this offices HIPPA policies and, I authorize disclosure of my medical records as described in the HIPPA pamphlet.

**I understand that payment is expected at the time of service. I choose to pay by (please check ✓):**

- |   |                                      |   |  |   |
|---|--------------------------------------|---|--|---|
| <input type="checkbox"/> Cash/Check     | <input type="checkbox"/> Credit Card | <input type="checkbox"/> Spouse's Insurance | <input type="checkbox"/> Worker's Comp Insurance | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Auto Insurance | <input type="checkbox"/> HMO         | <input type="checkbox"/> Medicare           | <input type="checkbox"/> Medicaid                | <input type="checkbox"/> General Health Insurance (PPO) |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

1. Rate the intensity/severity of your problem on a scale of 1 to 10 (10 being the worst): \_\_\_\_\_
2. When did your condition begin and how? \_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had this condition before? No  Yes  please explain \_\_\_\_\_  
\_\_\_\_\_
4. How often does this condition bother you? \_\_\_\_\_ constantly \_\_\_\_\_ x/day \_\_\_\_\_ x/week
5. Have you seen **ANY** other doctors for this condition? Please **LIST** their name, location and what services they performed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Have you missed any work as a result of your condition? Starting? \_\_\_\_\_ If yes, how much? \_\_\_\_\_  
\_\_\_\_\_
7. Has this condition interfered with any of the following? No  Yes  - please circle all that apply  
sleep                      immune system                      job                      appetite                      energy level
8. Have you noticed any changes in your functional habits? No  Yes  - please circle all that apply  
appetite                      bowel movements                      urination                      menstrual cycle  
other \_\_\_\_\_
9. List **ALL** the prescriptions, over the counter medications and nutritional/herbal supplements you are taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. List **ALL** the surgical procedures you have **ever** had, if you have **ever** been hospitalized and what for, and any motor vehicle accidents **ever**:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. What is your height and weight? \_\_\_\_\_
12. Please **LIST** which family members have: Cancer  Arthritis  Rheumatoid arthritis  Stroke   
Down's syndrome  Prostate problems  Other  \_\_\_\_\_  
\_\_\_\_\_
13. **Females** -Are you pregnant? No  - Yes  due date \_\_\_\_\_ Last Menstrual Period \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

MCCORMACK CHIROPRACTIC, S.C. • 519 Shepherds Drive • West Bend WI 53090 • (262)-306-9775

**McCormack Chiropractic, S.C.**  
Doctor-Patient Relationship in Chiropractic  
Informed consent

**CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of Chiropractic, osteopathy, and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on the environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

**ANALYSIS**

A doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures are given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defect, deformities, or pathologies may render the patient susceptible to injury. I understand as with any health care procedure that certain complications may rarely occur, such as fractures, muscle strains, arterial dissections, or others. The Doctor, of course, will not give a Chiropractic adjustment, or treatment, that will knowingly cause injury if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

**RESULTS**

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response to care is phenomenal. There may be times when treatment procedures cause discomfort due to the process of changing body structures.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond to Chiropractic care may come under control or be helped through medical science.

**TO THE PATIENT**

Please discuss any questions or problems with the Doctor regarding this statement of policy.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date