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

Mothers Name:_____MI:_____ SSN: _____Employer:_____

Mothers Address_____City,State,Zip_____Mothers Birthdate_____

Fathers Name: _____MI:_____ SSN: _____Employer:_____

Fathers Address_____City,State,Zip_____Fathers Birthdate_____

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)	Ear Infection
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)	Colic	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? _____

Females Only: Are you pregnant at this time? (No) (Yes)

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 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 understand that I am responsible for and/all legal costs associated with the collection process.

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 agree that a photocopy of this agreement shall serve as the original. 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 √):

____ Cash/Check ____ Credit Card ____ Spouse's Insurance ____ Worker's Comp Insurance ____ Auto Insurance

____ HMO ____ Medicare ____ Medicaid ____ Other _____ ____ 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