**Back In Balance Chiropractic, LLC**

Date\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What do you prefer to be called\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_Weight:\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_\_-\_\_­­\_­\_\_\_\_\_\_

**Contact Preference**: Home Phone Cell Phone Email Postal Mail

If you would like to get reminder texts, we need to know your **Cell Carrier**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Language:** English Spanish Chinese Asian Other\_\_\_\_\_\_\_\_\_\_\_\_

**Race/Ethnicity**: White or Caucasian Black or African American Hispanic or Latino Asian

 American Indian or Alaska Native Native Hawaiian/Other Pacific Islander Decline to Answer

**Work status**: Working Unemployed Disabled Retired Homemaker

**Occupation /Employer** (current/most recent):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**: Married Single Separated Divorced Widowed

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any children**? No Yes, How many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is your Family Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been to a chiropractor or acupuncturist before? No Yes Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your visit due to an auto or work related accident? No Yes

**Insurance Information**: *A copy of your insurance card(s) will be made, in addition, please complete the information requested below.*

Are you the policy holder? Yes No If No, who is? Spouse Parent Employer Other\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s First Name MI Last Name DOB:

Policy Holder’s Social Security #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have **Secondary** Insurance? Yes No If yes, please complete the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s First Name MI Last Name DOB:

Policy Holder’s Social Security #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient History**:

**Tobacco use**: Never Former Smoker Current/Every Day Smoker Current Some Day(s) Smoker

 If Former Smoker, when did you quit? \_\_\_\_\_\_\_\_\_\_ How many packs/day did you smoke\_\_\_\_\_\_

 If Current Smoker, how long have you smoked? \_\_\_\_\_\_\_\_\_\_ How many packs/day?\_\_\_\_\_\_\_\_\_\_

**Alcohol**: Never Rare Social (how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Alcoholic Recovering Alcoholic

**Drug abuse**: Never Currently In the past

**Exercise**: None Light Moderate Heavy \_\_\_\_\_ hours per week

**For Women:** Are you taking Birth Control? Yes No

Are you nursing? Yes No Are you pregnant? Yes No if so, how many weeks? \_\_\_\_\_\_\_\_\_\_\_

**Do you have Allergies**? Food Environmental Medication None

List type of Allergy and Reaction(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications/ Vitamins/ Supplements (*Please list both prescription and non-prescription)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical History: *(Please list all previous surgeries, the surgeon and date***) None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Review of Systems:** *Please circle any condition you are* ***currently*** *experiencing.*

**Constitutional:** Fever Weight loss Weight gain Chills Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic:** Headache Dizziness Memory Loss Numbness Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes:** Glasses Contacts Double vision Blurriness Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears/Throat:** Deafness Ringing Hoarseness Swallowing difficulty Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiac:** Chest pain Skip beats Rapid beat Edema/ankle swelling Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pulmonary:** Cough Cough blood Short of breath Wheezing Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intestinal:** Diarrhea Bleeding Incontinence Constipation Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary:** Burning Bleeding Incontinence Increased Frequency Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal:** Pain Weakness Arthritis Joint Swelling Cane/walker Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin:** Bruising Lesions Birth marks Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematologic:** Bleeding Transfusions Hepatitis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric:** Depression Insomnia Fatigued Nervous exhaustion Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Miscellaneous:** Metal implants Breast Implants Claustrophobic Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: *Please check any problems that run in your family.***

Yes No Yes No Yes No

heart attack

heart trouble asthma

diabetes

stroke

aneurysm

gout

kidney trouble/stones

bleeding disorder arthritis alcoholism mental illness

cancer - if yes what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History: *Do you have or have you had any of the following*?**

Yes No Yes No Yes No

heart attack

heart failure

heart valve

high blood pressure

heart murmur asthma pacemaker abnormal rhythm

COPD emphysema tuberculosis diabetes Type: I II

thyroid trouble stroke

aneurysm

ulcers

reflux disease liver trouble hepatitis

kidney trouble

kidney stones urinary problems anemia

bleeding disorder

blood transfusion osteoarthritis rheumatoid arthritis

gout

depression bipolar

schizophrenia neuropathy alcoholism HIV/Aids

cancer

low back pain serious injury

blood clots

osteoporosis

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
* We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
* I have had an opportunity to review the clinics HIPAA policy and have been afforded an opportunity to receive a copy of it and understand that I may ask for one at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What are your complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rate your pain with the following scale:**

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

When did this condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_ Please explain what happened? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition getting worse better constant comes and goes

Have you found anything to make it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you found anything that makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this or something similar happened in the past? Yes No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatments have included**: No medications, therapy, injections, braces or casts.

Physical therapy or exercise

Anti-inflammatory meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Massage

Narcotic meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Traction

Braces

Manipulation/chiropractic

Cortisone injections, how many? \_\_\_\_\_\_\_

Acupuncture

Previous doctors seen for this problem: None

Doctor Specialty Date Treatments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tests done to evaluate your problem**: None *Please list date of studies, results, and where study done if known.*

Plain X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI/CT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMG/NCV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other tests \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle all affected areas on the body chart:**

Back In Balance Chiropractic, LLC | Brock Falconer, D.C.

**INFORMED CONSENT TO TREATMENT**

The Nature of Chiropractic Treatment: The doctor will use his/ her hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop”, and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, massage, electrical muscle stimulation, ultrasound, traction or therapeutic activities may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bones, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered “rare.”

Acupuncture: Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and

dizziness or fainting.

Other Treatment Options Which Could Be Considered May Include the Following:

* Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
* Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
* Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable diseases in a significant number of cases.
* Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above of chiropractic treatment and I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date