Welcome to our office! This paperwork provides the vital information required to be a patient! Our staff will personally interview you for the condition or concerns that bring you here!

Full Legal Name:_____ Preferred Name:_____
Address:_____ City / State / Zip: _____
Home Phone: _____ Mobile Phone: _____
Birth Date: _____ Age: _____
Social Security #: _____
E:mail: _____
Marital Status: (Circle One) Single Married Divorced Widowed
Spouse's Name: _____ Number of Children: _____

Occupation / Employers Name: _____
Work Phone: ( )_____

Insurance:
Insurance Type: _____
Policyholder: _____DOB:_____

Emergency Contact:
Name: _____ Relation:_____
Home Phone: _____Work Phone: _____

Information may be released to the following individuals (such as spouse, mother, father):

***** No information will be released to anyone unless noted here, including billing or statement information.

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Drinking Status (Circle One): Never/ Rarely / Social Drinks Beer or Liquor:_____/day, week, month

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Prior Health History -- Circle all the apply

Musculoskeletal Conditions:
Arthritis
Back Problems
Cramping
Elbow/wrist pain
Foot/ankle pain
Fracture
Gout
Hip Disorders
Implants or plates
Joint or muscle pains/stiffness
Knee Injuries
Neck Pain
Osteoporosis
Pins or Screws
Poor Posture
Scoliosis
Shoulder Problems
Swelling, redness deformity of joint
TMJ issues

Neurological:
Anxiety and/or panic
Depression
Difficulty Concentrating
Dizziness
Epilepsy or Seizures
Headache
Loss of Smell or Taste
Memory Issues
Numbness
Sleeping Issues
Stroke
Temporary loss of vision, smell or hearing
Weak Muscles

Head & ENT:
Blurred or double vision
Cataracts
Chronic Ear Infections
Dental Problems
Difficulty Swallowing
Ear or Hearing Problems
Earache
Eye or Vision Problems
Eyeglasses or Contacts
Glaucoma
Headaches or Migraines
Ringing in the ears

Cardiovascular:
Chest pain or tightness
Congenital heart defects
Coronary artery disease
Heart attack
Heart murmur
High blood pressure
High cholesterol
Palpitations
Swollen legs or feet
Varicose Veins

Respiratory:
Apnea
Asthma
Emphysema
Pneumonia
Shortness of breath
Snoring issues
Tuberculosis
Wheezing

Genitourinary:
Blood in the urine
Incontinence
Kidney stones
Painful or frequent urination
Urinary infections

Female:
Birth Control Therapy
Hormone Therapy
Irregular Menstruation
Abnormal Bleeding
Currently Pregnant
Pregnant in the past

Male:
Erectile Dysfunction
Hesitancy/Dribbling
Prostate Problems

Endocrine:
Diabetes
Excessive thirst
Hyperthyroidism
Hypothyroidism
Pancreatic conditions
Thyroid Problems

Dermatological or Hematopoietic:
Blood in stool
Change in hair or nails
Easy bruising
Eczema
Hair loss
Skin trouble or rashes

Allergy/Sensitivity:
Animal dander/fur
Dust
Nuts
Pollen
Seafood

Surgeries:
_____
_____
_____

Illnesses:
ADD/ADHD
Bedwetting
Ear Infections
Chicken Pox
Measles
Mumps
Scoliosis
Cancer
Crohn's/Colitis
Cystic Kidney disease
Liver disease
Parkinson's disease
Seizure disorder
Shingles
Vertigo
Other:_____

Family history:
_____
_____
_____

Past Injury/Accidents:
_____
_____
_____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ , have been informed, understand and agree to the Notice of Privacy Practices of Wager Chiropractic PLLC which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I have been offered the full policy pamphlet.

Signature: _____ **Print Name:** _____

Clinical Summary

I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care).

Signature: _____

Authorization and Assignment

I authorize Wager Chiropractic PLLC 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.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Wager Chiropractic PLLC authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. 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 or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

I understand if I do not provide Wager Chiropractic PLLC with insurance information within my insurance companies timely filing guidelines, Wager Chiropractic PLLC has the right to not submit to my insurance company and the balance is my responsibility to pay in full.

Signature: _____ **Date:** _____

Informed Consent

I hereby authorize physicians and staff at Wager Chiropractic PLLC to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Wager Chiropractic PLLC responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, ten- don, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Signature: _____ **Date:** _____

Consent to Treat a Minor

I, as a parent/legal guardian of _____ authorize appropriate chiropractic care.

Signature: _____ **Date:** _____