Winters® Chiropractic & Physical Therapy

REGISTRATION AND HISTORY

PATIENT INFORMATION

Preferred Name_____Date_____

Patient Name_____
Last First MI

Address_____

_____
City State Zip

Email_____

Sex: ❑ M ❑ F Age_____ Birth Date_____

Dominant Hand: ❑ L ❑ R ❑ Both

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#_____

Occupation_____

Employer_____

Spouse's Name_____

Birth Date_____Occupation_____

Primary MD_____

Clinic Name/Phone_____

Do you give us permission to release your clinical records/status to your primary MD? ❑ Yes ❑ No

PHONE NUMBERS

Home_____ Cell_____

Work_____ Ext_____

Emergency Contact Name_____

Relationship_____

Best number(s) to contact them_____

INSURANCE AND ATTORNEY INFORMATION

Date of Injury_____

Is a claim filed with the Workers' Comp. Company? ❑ Yes ❑ No

Workers' Comp. Co. Name_____

Claim #_____

Adjustor/Contact Name_____

Adjustor/Contact Phone #_____

Do you have an Attorney? ❑ Yes ❑ No

Name of Attorney_____

Contact Name_____

Contact Phone #_____

Do you have Health Insurance? ❑ Yes ❑ No

If yes, name of Health Ins. Co._____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

Workers' Comp. Co. _____

Name of Attorney _____

Name of Health Ins. Co. _____

and assigns directly to Winters Chiropractic & Physical Therapy, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

HEALTH HISTORY

Prior Injuries/Surgeries	Description	Date
Falls		
Head injuries		
Broken bones		
Dislocations		
Surgeries		

General
- ❑ bruise easily
- ❑ chills
- ❑ dental problems
- ❑ depression
- ❑ difficulty sleeping
- ❑ dizziness
- ❑ fainting
- ❑ fever
- ❑ forgetfulness
- ❑ headache
- ❑ loss of sleep
- ❑ loss of weight
- ❑ nervousness
- ❑ numbness
- ❑ sweats
- ❑ tiredness
- ❑ weight gain

Gastrointestinal
- ❑ appetite poor
- ❑ bloating
- ❑ bowel changes
- ❑ constipation
- ❑ diarrhea
- ❑ excessive hunger
- ❑ excessive thirst
- ❑ gas
- ❑ hemorrhoids
- ❑ indigestion
- ❑ nausea
- ❑ rectal bleeding
- ❑ stomach pain
- ❑ vomiting
- ❑ vomiting blood

Eye, Ear, Nose, Throat
- ❑ bleeding gums
- ❑ blurred vision
- ❑ crossed eyes
- ❑ difficulty swallowing
- ❑ double vision
- ❑ earache
- ❑ ear discharge
- ❑ hay fever
- ❑ hoarseness
- ❑ loss of hearing
- ❑ nose bleeds
- ❑ persistent cough
- ❑ ring in ears
- ❑ sinus problems
- ❑ vision-flashes
- ❑ vision-halos

Genito-Urinary
- ❑ blood in urine
- ❑ frequent urination
- ❑ lack of bladder control
- ❑ painful urination

Skin
- ❑ bruise easily
- ❑ hives
- ❑ itching
- ❑ changes in moles
- ❑ rash
- ❑ scars
- ❑ sore that won't heal

Cardiovascular
- ❑ chest pain
- ❑ high blood pressure
- ❑ irregular heart beat
- ❑ low blood pressure
- ❑ poor circulation
- ❑ rapid heart beat
- ❑ swelling of ankles
- ❑ varicose veins

Men Only
- ❑ breast lump
- ❑ erection difficulties
- ❑ lump in testicles
- ❑ penis discharge
- ❑ sore on penis

Women Only
- ❑ abnormal pap smear
- ❑ bleeding between
- ❑ period
- ❑ breast lump
- ❑ extreme menstrual pain

Date of last menstruation

_____

Date of last pap smear

_____

- ❑ hot flashes
- ❑ nipple discharge
- ❑ painful intercourse
- ❑ vaginal discharge

Are you pregnant?
❑ Yes ❑ No

Number of children_____

Have you had a mammogram?
❑ Yes ❑ No

Exercise _____hrs/wk
- ❑ none
- ❑ moderate
- ❑ daily
- ❑ heavy

Work Activity
- ❑ sitting
- ❑ standing
- ❑ light labor
- ❑ heavy labor

Habits
- ❑ smoking packs/day _____
- ❑ alcohol drinks/week _____
- ❑ coffee/caffeine drinks cups/day _____
- ❑ high stress level Reason_____

CONDITIONS check current and past conditions.
- ❑ AIDS
- ❑ alcoholism
- ❑ anemia
- ❑ anorexia
- ❑ appendicitis
- ❑ arthritis
- ❑ asthma
- ❑ bleeding disorders
- ❑ breast lump
- ❑ bronchitis
- ❑ bulimia
- ❑ cancer
- ❑ cataracts
- ❑ chemical dependency
- ❑ chicken pox
- ❑ diabetes
- ❑ emphysema
- ❑ epilepsy
- ❑ fractures
- ❑ glaucoma
- ❑ goiter
- ❑ gonorrhea
- ❑ gout
- ❑ heart disease
- ❑ hepatitis
- ❑ hernia
- ❑ herpes
- ❑ high cholesterol
- ❑ HIV positive
- ❑ kidney disease
- ❑ liver disease
- ❑ measles
- ❑ migraine headaches
- ❑ miscarriage
- ❑ mononucleosis
- ❑ multiple sclerosis
- ❑ mumps
- ❑ osteoporosis
- ❑ pacemaker
- ❑ pneumonia
- ❑ polio
- ❑ prostate
- ❑ prosthesis
- ❑ psychiatric disorder
- ❑ rheumatoid arthritis
- ❑ rheumatic fever
- ❑ scarlet fever
- ❑ stroke
- ❑ suicide attempt
- ❑ thyroid problems
- ❑ tonsillitis
- ❑ tuberculosis
- ❑ tumors, growths
- ❑ typhoid fever
- ❑ ulcers
- ❑ vaginal infections
- ❑ venereal disease
- ❑ whopping cough
- ❑ other_____

_____

Medications _____

_____

Please describe your injury below:
(IF this injury was due to a work related auto accident please complete page 4 instead of the boxes below)

1. Description of Injury/Onset (Explain how you got the injury):

2. During and After Injury/Onset Details (How you felt after the injury):

ONLY NEED TO COMPLETE THIS PAGE IF INJURY WAS DUE TO A WORK RELATED AUTO ACCIDENT

Your Vehicle Type:

❑ Car ❑ S.U.V. ❑ Van ❑ Bus

❑ Large Truck ❑ Pickup Truck

❑ Other_____

Your Position in Vehicle:

❑ Driver ❑ Front passenger

❑ Left rear passenger ❑ Right rear passenger

❑ Other_____

Time/Speed/Damage:

Accident Time_____❑ AM ❑ PM

Your vehicle's speed _____mph

Their vehicle's speed _____mph

Damage to your vehicle:

❑ Mild ❑ Moderate ❑ Totaled

What was your vehicle doing at the time of the accident:

❑ stopped at intersection ❑ stopped in traffic ❑ stopped at light

❑ making a right turn ❑ making a left turn ❑ slowing down

❑ proceeding along ❑ accelerating ❑ parking

Visibility at the time:

❑ good

❑ fair

❑ poor

Road conditions at the time of the accident:

❑ icy ❑ wet ❑ sandy ❑ dark ❑ clean and dry

Who hit who/what?

❑ you hit other vehicle

❑ other vehicle hit you

❑ you hit…(write object below)

_____

Point of impact:

❑ head-on ❑ rear-end

❑ left front ❑ right front

❑ left rear ❑ right rear

Body position, ect.

Did you see the accident coming? ❑ Yes ❑ No

Were you braced for the impact? ❑ Yes ❑ No

Were you wearing your seatbelt? ❑ Yes ❑ No

Did you have your shoulder harness on? ❑ Yes ❑ No

Did the driver's forward airbag deploy? ❑ Yes ❑ No

Did passenger's forward airbag deploy? ❑ Yes ❑ No

Did the side airbags deploy? ❑ Yes ❑ No

Does your vehicle have headrests? ❑ Yes ❑ No

Headrest position?

❑ even with top of head

❑ even with bottom of head

❑ middle of neck

What was the direction of the head at the time of impact?

❑ facing straight forward

❑ turned to the right

❑ turned to the left

During the accident:

Did your body strike the inside of your vehicle? ❑ Yes ❑ No If yes, describe_____

_____

Did you lose consciousness during the injury? ❑ Yes ❑ No If yes, describe_____

_____

Your vehicles estimated damage: $_____ **Did the police show up at the scene?** ❑ Yes ❑ No

Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled **Was an accident report filled out?** ❑ Yes ❑ No

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE
(There are 3 pages for symptoms and more can be printed if needed)

1st WORST Current Symptom

Please choose ONE symptom from the list below and complete this page for that symptom.

Symptom #1 (circle one):

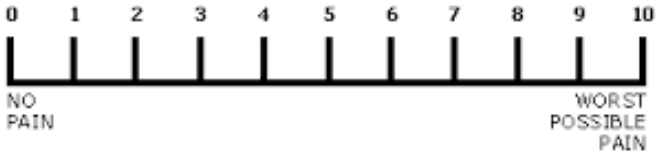
Low Back	Mid Back	Upper Back
Neck	Upper Arm	Shoulder
Head (front)	Chest	Abdomen
Head (top)	Ribs	Buttocks
Head (sides)	Forearm	Hand
Head (back)	Leg	Hip
Foot	Jaw	Eye

Other Location (specify)

Location of Pain:

❑ Left ❑ Right ❑ Both

Pain Scale (circle):



Does this pain radiate into other body parts?

❑ Yes ❑ No

	Left	Right	Both
Head	❑	❑	❑
Neck	❑	❑	❑
Shoulder	❑	❑	❑
Arm	❑	❑	❑
Hand	❑	❑	❑
Hip	❑	❑	❑
Leg	❑	❑	❑
Foot	❑	❑	❑

Other_____

Type of Pain (mark all that apply):

❑ Dull
❑ Throbbing
❑ Spasm
❑ Sharp
❑ Burning
❑ Stinging
❑ Aching
❑ Numbing
❑ Shooting
❑ Cutting
❑ Tingling
❑ Pounding
❑ Cramping
❑ Constricting

Pain Frequency:

❑ Up to ¼ of awake time
❑ Up to ¼ to ½ of awake time
❑ Up to ½ to ¾ of awake time
❑ Most all of the time

Pain Intensity (how it affects your daily activities):

❑ Doesn't affect
❑ Somewhat affects
❑ Seriously affects
❑ Prevents activities

Actions Affecting This Pain:

	Brings on	Aggravates	Relieves
In the A.M.	❑	❑	❑
In the P.M.	❑	❑	❑
Bending forward	❑	❑	❑
Bending back	❑	❑	❑
Bending left	❑	❑	❑
Bending right	❑	❑	❑
Twisting left	❑	❑	❑
Twisting right	❑	❑	❑
Coughing	❑	❑	❑
Sneezing	❑	❑	❑
Straining	❑	❑	❑
Standing	❑	❑	❑
Sitting	❑	❑	❑
Lifting	❑	❑	❑

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE
(There are 3 pages for symptoms and more can be printed if needed)

2nd Current Symptom

Please choose ONE symptom from the list below and complete this page for that symptom.

Symptom #2 (circle one):

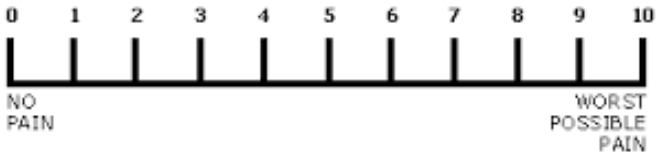
Low Back	Mid Back	Upper Back
Neck	Upper Arm	Shoulder
Head (front)	Chest	Abdomen
Head (top)	Ribs	Buttocks
Head (sides)	Forearm	Hand
Head (back)	Leg	Hip
Foot	Jaw	Eye

Other Location (specify)

Location of Pain:

❑ Left ❑ Right ❑ Both

Pain Scale (circle):



Does this pain radiate into other body parts?

❑ Yes ❑ No

	Left	Right	Both
Head	❑	❑	❑
Neck	❑	❑	❑
Shoulder	❑	❑	❑
Arm	❑	❑	❑
Hand	❑	❑	❑
Hip	❑	❑	❑
Leg	❑	❑	❑
Foot	❑	❑	❑

Other_____

Type of Pain (mark all that apply):

❑ Dull
❑ Throbbing
❑ Spasm
❑ Sharp
❑ Burning
❑ Stinging
❑ Aching
❑ Numbing
❑ Shooting
❑ Cutting
❑ Tingling
❑ Pounding
❑ Cramping
❑ Constricting

Pain Frequency:

❑ Up to ¼ of awake time
❑ Up to ¼ to ½ of awake time
❑ Up to ½ to ¾ of awake time
❑ Most all of the time

Pain Intensity (how it affects your daily activities):

❑ Doesn't affect
❑ Somewhat affects
❑ Seriously affects
❑ Prevents activities

Actions Affecting This Pain:

	Brings on	Aggravates	Relieves
In the A.M.	❑	❑	❑
In the P.M.	❑	❑	❑
Bending forward	❑	❑	❑
Bending back	❑	❑	❑
Bending left	❑	❑	❑
Bending right	❑	❑	❑
Twisting left	❑	❑	❑
Twisting right	❑	❑	❑
Coughing	❑	❑	❑
Sneezing	❑	❑	❑
Straining	❑	❑	❑
Standing	❑	❑	❑
Sitting	❑	❑	❑
Lifting	❑	❑	❑

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE
(There are 3 pages for symptoms and more can be printed if needed)

3rd Current Symptom

Please choose ONE symptom from the list below and complete this page for that symptom.

Symptom #3 (circle one):

Low Back	Mid Back	Upper Back
Neck	Upper Arm	Shoulder
Head (front)	Chest	Abdomen
Head (top)	Ribs	Buttocks
Head (sides)	Forearm	Hand
Head (back)	Leg	Hip
Foot	Jaw	Eye
Other Location (specify)		

Location of Pain:

❑ Left ❑ Right ❑ Both

Pain Scale (circle):

Does this pain radiate into other body parts?

❑ Yes ❑ No

	Left	Right	Both
Head	❑	❑	❑
Neck	❑	❑	❑
Shoulder	❑	❑	❑
Arm	❑	❑	❑
Hand	❑	❑	❑
Hip	❑	❑	❑
Leg	❑	❑	❑
Foot	❑	❑	❑

Other_____

Type of Pain (mark all that apply):

❑ Dull
❑ Throbbing
❑ Spasm
❑ Sharp
❑ Burning
❑ Stinging
❑ Aching
❑ Numbing
❑ Shooting
❑ Cutting
❑ Tingling
❑ Pounding
❑ Cramping
❑ Constricting

Pain Frequency:

❑ Up to ¼ of awake time
❑ Up to ¼ to ½ of awake time
❑ Up to ½ to ¾ of awake time
❑ Most all of the time

Pain Intensity (how it affects your daily activities):

❑ Doesn't affect
❑ Somewhat affects
❑ Seriously affects
❑ Prevents activities

Actions Affecting This Pain:

	Brings on	Aggravates	Relieves
In the A.M.	❑	❑	❑
In the P.M.	❑	❑	❑
Bending forward	❑	❑	❑
Bending back	❑	❑	❑
Bending left	❑	❑	❑
Bending right	❑	❑	❑
Twisting left	❑	❑	❑
Twisting right	❑	❑	❑
Coughing	❑	❑	❑
Sneezing	❑	❑	❑
Straining	❑	❑	❑
Standing	❑	❑	❑
Sitting	❑	❑	❑
Lifting	❑	❑	❑

Emergency Room:

Where did you go after onset of your symptoms?

- ❑ Home
- ❑ Work
- ❑ Hospital ER _____
- ❑ Private Doctor _____

(Please provide name of Hospital or Private Doctor if applicable)

How did you get there?

- ❑ Drove self
- ❑ Somebody else drove me
- ❑ Ambulance
- ❑ Police

Were x-rays done? ❑ Yes ❑ No

Was lab work done? ❑ Yes ❑ No

Body parts x-rayed? _____

What lab work was done? _____

Results of x-rays? _____

Results of lab work? _____

Treatment received? ❑ Cervical collar ❑ Ice ❑ Other_____

Medications prescribed: _____

Follow-up instructions: _____

After the Accident: check off your symptoms immediately after and a few days following the accident.

❑ headache	❑ loss of smell	❑ tension	❑ loss of taste	❑ diarrhea
❑ neck pain	❑ dizziness	❑ irritability	❑ toe numbness	❑ depression
❑ neck stiffness	❑ nausea	❑ mid back pain	❑ constipation	❑ anxious
❑ fainting	❑ confusion	❑ low back pain	❑ cold hands	❑ chest pain
❑ ringing in ears	❑ fatigue	❑ nervousness	❑ cold feet	
❑ pain behind eyes	❑ shortness of breath	❑ sleeping problems		

❑ others: _____

Prior Similar Symptoms:

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your history contributed to your current symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I'm NOT SURE if my history has contributed to my current symptoms.

(If applicable) My most recent prior similar symptoms occurred _____

Treatment History: fill in any other doctor(s) seen in regards to the accident

1. Dr. _____ Specialty_____ First visit ___/___/___

Types of treatment received:_____

X-rays done? ❑ Yes ❑ No How many treatments? _____ Did treatment benefit you? ❑ Yes ❑ No

Currently treating? ❑ Yes ❑ No Last visit ___/___/___

2. Dr. _____ Specialty_____ First visit ___/___/___

Types of treatment received:_____

X-rays done? ❑ Yes ❑ No How many treatments? _____ Did treatment benefit you? ❑ Yes ❑ No

Currently treating? ❑ Yes ❑ No Last visit ___/___/___

Activities of Daily Living Assessment

Use the following 1 to 5 scale and check the appropriate box next to the number that most closely describes your current degree of difficulty. Only check the activities you do and only ONE box per activity.

Difficulties with Self Care and Personal Hygiene	Able to do without difficulty	Able to do despite some pain	Able to do despite marked pain	Able to do with help despite the pain	Unable to do at all due to pain
	1	2	3	4	5
1. Bathing	❑	❑	❑	❑	❑
2. Drying hair	❑	❑	❑	❑	❑
3. Brushing teeth	❑	❑	❑	❑	❑
4. Putting on shoes	❑	❑	❑	❑	❑
5. Preparing meals	❑	❑	❑	❑	❑
6. Taking out trash	❑	❑	❑	❑	❑
7. Showering	❑	❑	❑	❑	❑
8. Combing hair	❑	❑	❑	❑	❑
9. Making bed	❑	❑	❑	❑	❑
10. Tying shoes	❑	❑	❑	❑	❑
11. Eating	❑	❑	❑	❑	❑
12. Doing laundry	❑	❑	❑	❑	❑
13. Washing hair	❑	❑	❑	❑	❑
14. Washing face	❑	❑	❑	❑	❑
15. Putting on shirt	❑	❑	❑	❑	❑
16. Putting on pants	❑	❑	❑	❑	❑
17. Cleaning dishes	❑	❑	❑	❑	❑
18. Going toilet	❑	❑	❑	❑	❑
Physical Activity Difficulties	**1**	**2**	**3**	**4**	**5**
1. Standing	❑	❑	❑	❑	❑
2. Walking	❑	❑	❑	❑	❑
3. Kneeling	❑	❑	❑	❑	❑
4. Bending back	❑	❑	❑	❑	❑
5. Twisting left	❑	❑	❑	❑	❑
6. Leaning back	❑	❑	❑	❑	❑
7. Sitting	❑	❑	❑	❑	❑
8. Stooping	❑	❑	❑	❑	❑
9. Reaching	❑	❑	❑	❑	❑
10. Bending left	❑	❑	❑	❑	❑
11. Twisting right	❑	❑	❑	❑	❑
12. Leaning left	❑	❑	❑	❑	❑
13. Reclining	❑	❑	❑	❑	❑
14. Squatting	❑	❑	❑	❑	❑
15. Bending forward	❑	❑	❑	❑	❑
16. Bending right	❑	❑	❑	❑	❑
17. Leaning forward	❑	❑	❑	❑	❑
18. Leaning right	❑	❑	❑	❑	❑
19. Standing for long periods	❑	❑	❑	❑	❑
20. Sitting for long periods	❑	❑	❑	❑	❑
21. Walking for long periods	❑	❑	❑	❑	❑
22. Kneeling for long periods	❑	❑	❑	❑	❑

Difficulties with Functional Activities	Able to do without difficulty	Able to do despite some pain	Able to do despite marked pain	Able to do with help despite the pain	Unable to do at all due to pain
	1	**2**	**3**	**4**	**5**
1. Carrying small objects	❑	❑	❑	❑	❑
2. Lifting weights off the floor	❑	❑	❑	❑	❑
3. Pushing things while seated	❑	❑	❑	❑	❑
4. Exercising upper body	❑	❑	❑	❑	❑
5. Carrying large objects	❑	❑	❑	❑	❑
6. Lifting weights off table	❑	❑	❑	❑	❑
7. Pushing things while standing	❑	❑	❑	❑	❑
8. Exercising lower body	❑	❑	❑	❑	❑
9. Carrying brief case	❑	❑	❑	❑	❑
10. Climbing stairs	❑	❑	❑	❑	❑
11. Pulling things while seated	❑	❑	❑	❑	❑
12. Exercising arms	❑	❑	❑	❑	❑
13. Carrying large purse	❑	❑	❑	❑	❑
14. Climbing inclines	❑	❑	❑	❑	❑
15. Pulling things while standing	❑	❑	❑	❑	❑
16. Exercising legs	❑	❑	❑	❑	❑
Social & Recreational Difficulties	**1**	**2**	**3**	**4**	**5**
1. Bowling	❑	❑	❑	❑	❑
2. Jogging	❑	❑	❑	❑	❑
3. Swimming	❑	❑	❑	❑	❑
4. Ice skating	❑	❑	❑	❑	❑
5. Competitive sports	❑	❑	❑	❑	❑
6. Dating	❑	❑	❑	❑	❑
7. Golfing	❑	❑	❑	❑	❑
8. Dancing	❑	❑	❑	❑	❑
9. Skiing	❑	❑	❑	❑	❑
10. Roller skating	❑	❑	❑	❑	❑
11. Hobbies	❑	❑	❑	❑	❑
12. Dining out	❑	❑	❑	❑	❑
Traveling Difficulties	**1**	**2**	**3**	**4**	**5**
1. Driving a motor vehicle	❑	❑	❑	❑	❑
2. Passenger in motor vehicle	❑	❑	❑	❑	❑
3. Passenger on a train	❑	❑	❑	❑	❑
4. Driving for long periods	❑	❑	❑	❑	❑
5. Passenger on an airplane	❑	❑	❑	❑	❑
6. Passenger for long periods	❑	❑	❑	❑	❑

Difficulties with Different Forms of Communication	**Able to do without difficulty**	**Able to do despite some pain**	**Able to do despite marked pain**	**Able to do with help despite the pain**	**Unable to do at all due to pain**
	1	**2**	**3**	**4**	**5**
1. Concentrating	❑	❑	❑	❑	❑
2. Hearing	❑	❑	❑	❑	❑
3. Listening	❑	❑	❑	❑	❑
4. Speaking	❑	❑	❑	❑	❑
5. Reading	❑	❑	❑	❑	❑
6. Writing	❑	❑	❑	❑	❑
7. Using a keyboard	❑	❑	❑	❑	❑
Difficulties with Senses	**1**	**2**	**3**	**4**	**5**
1. Seeing	❑	❑	❑	❑	❑
2. Hearing	❑	❑	❑	❑	❑
3. Sense of Touch	❑	❑	❑	❑	❑
4. Sense of Taste	❑	❑	❑	❑	❑
5. Sense of Smell	❑	❑	❑	❑	❑
Difficulties with Hand Functions	**1**	**2**	**3**	**4**	**5**
1. Grasping	❑	❑	❑	❑	❑
2. Holding	❑	❑	❑	❑	❑
3. Pinching	❑	❑	❑	❑	❑
4. Percussion	❑	❑	❑	❑	❑
5. Sensory Discrimination	❑	❑	❑	❑	❑
Difficulties with Sleep & Sexual Function	**1**	**2**	**3**	**4**	**5**
1. Being able to have a normal, restful night's sleep	❑	❑	❑	❑	❑
2. Being able to participate in desired sexual activity	❑	❑	❑	❑	❑

Please write any other Activities of Daily Living NOT covered above.

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Informed Consent for Chiropractic/Physical Therapy Treatment

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 or 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 serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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, disk 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 then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its 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 see treatment.

TO BE COMPLETED BY PATIENT

Patient's Name_____ Signature of Patient_____

Date Signed_____ Witness or Patient's Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name_____ Signature of Patient_____

Date Signed_____Signature of Representative_____

Relationship or Authority of Patient's Representative_____

Translated by_____ Date _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office_____

Address_____

Name of Doctor's treating this patient:

1._____ PIN#_____

2._____ PIN#_____

3._____ PIN#_____