



CONFIDENTIAL PATIENT INFORMATION

Name: _____ Marital Status (M S D W) Age: _____ Birth Date: ____/____/____
Height: _____ Weight: _____ Sex (F M) Race: _____ Phone (H): _____ (W): _____
Spouse's Name: _____ Children: _____
Address (Street, City, State, Zip): _____

Medical Doctor: _____
Email Address: _____ Cell#: _____

Occupation: _____ How Long: _____ Employer: _____
Referred by: _____ Previous Chiropractic Care: _____

ACCIDENTS: Please describe, give date, injuries, broken bones, fractures, treatment
Automobile: _____
Occupational: _____
Recreational: _____
Childhood: _____
Operations/Surgeries (type/date): _____
X-Rays (date, where taken, of what, findings) _____

PRESENT COMPLAINT: _____ How Long?: _____ Is it constant?: _____
How did it occur?: _____ What relieves it?: _____

Please circle the symptoms you have noticed:

- Headache Dizziness/Faintness Eye/Vision Problems Cold Feet
Neck Pain/Stiff Loss of Smell Arm/Shoulder Pain Chest/Rib Pain
Upper Back Pain Loss of Taste Pins/Needles Arms Problems Breathing
Low Back Pain Problems Sleeping Finger Numbness Coughing
Pressure in Head Fever/Chills Cold Hands Stomach Upset
Loss of Balance Fatigue/Depression Leg/Hip Pain Bowel Problems
EarAche/Ringing Nervousness Pins/Needles Toes Indigestion
Irritability Stress/Tension Numbness in Toes Urination Problems

Symptoms not listed above: _____

Other doctors seen for this condition: _____

What medications are you taking: _____

Please circle any in your family history:

Heart disease — Diabetes — Arthritis — Cancer — Back problems

Health Questions:

Do you smoke? _____ Drink alcoholic beverages? _____ Eat a well-balanced diet? _____ Sleep 6-8 hours? _____ Daily Exercise? _____

NO SYMPTOMS EXTREME SYMPTOMS

1 _____ 10 Place
an "X" on the line above to indicate the level of the problem.

Patient or Guardian's Signature: _____ Date: _____



INFORMED CONSENT

PATIENT NAME _____

Clinic Name: 180° Chiropractic Wellness Center, LLC

Doctor's Name: Dr. Joshua Ebert

At this office, our goal is simple! Our main purpose is to locate, analyze and correct vertebral subluxations for health, wellness and maintenance care.

I understand that chiropractic care is given to correct misalignments of the spine called **SUBLUXATIONS**. One of the benefits of a chiropractic adjustment is that you **MAY** feel better but this is not the **GOAL** of an adjustment. The goal of an adjustment is to correct **SUBLUXATIONS**, thereby removing possible interference to the nervous system allowing the body to heal itself. As a result, **WE DO NOT TREAT PAIN/ DISEASE AND/OR MEDICAL NECESSITY**; we remove subluxations so that the body is able to function properly and be better enabled to heal itself.

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" sound as part of the process. This is said to be built up pressure in the joint being released similar to popping your knuckles.

There are certain side effects that can occur as a result of a spinal manipulation. These include, but are not limited to: dizziness, nausea, muscle strain and swelling. In rare cases, complications include disc and vertebral injury, fractures, strains and dislocations. The most common symptom or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these symptoms/complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays in office or referral out of office. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

Financial Policy for 180 Chiropractic Wellness Center, LLC

At our office, we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered our business procedures to keep our fees reduced.

Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please ask so there is no confusion moving forward?

We are treating subluxations for the sole purpose of wellness/maintenance. This is not covered by most if not all insurance companies.

You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office.

We take no responsibility for non-payment by insurance companies for services rendered at our office.

Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.

No balances can be kept or run by patients at any time. All adjustment visits are paid immediately prior to the service being rendered. All initial visits and if applicable, x-rays are paid for upon completion of these services.

Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I have read, understand and agree to all terms.

I understand that I am under no obligation to receive or continue care.

Print your name _____ Sign your name _____

Today's Date _____