COMPLETE CARE *Chiropractic*

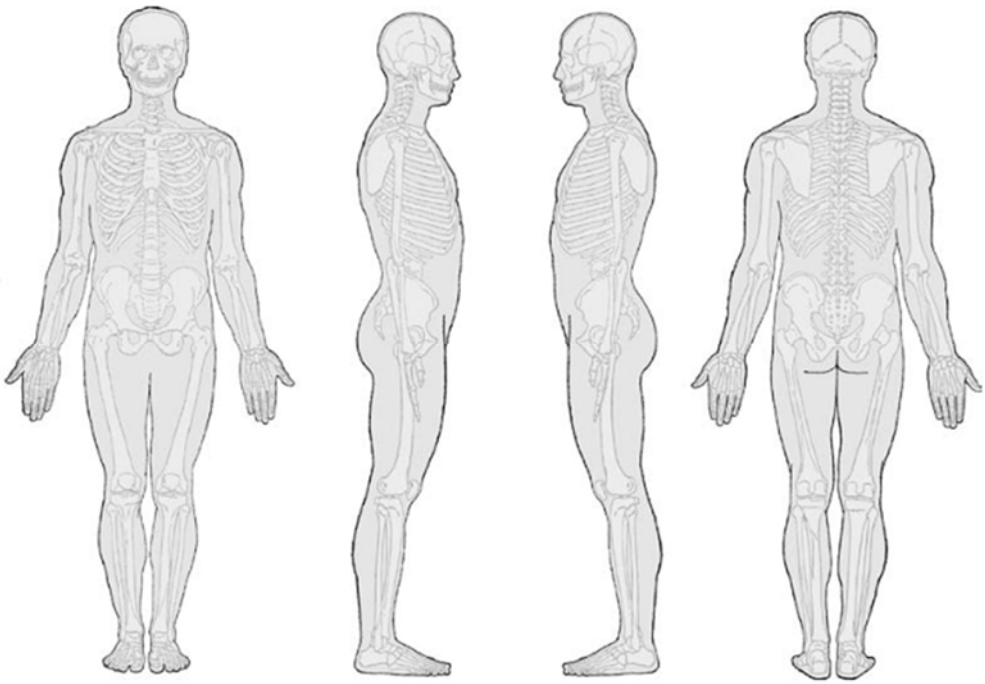
Welcome to Complete Care and thank you for choosing us!		
Name		Gender: M / F
Address		
Phone: Home		Mobile
D.O.B.	E-mail address	
Occupation		
Pregnant? Y / N	Marital status: M S W D	Partner's name
Names & ages of children		
Have you had previous chiropractic care?		
How did you hear about our office?		

If you have no symptoms or complaints and are here for a general health check, please skip to the "General Health History" on page 2.

Clients of Complete Care consult our offices for a number of reasons. Please list your concerns that you would like addressed.

Please list your health concerns.	Severity from 1=mild to 10=worst imaginable	When did this episode start?	Has this happened before? When?	What caused this problem?
1.				
2.				
3.				

Please mark on the diagram where you experience pain, or have an injury.



Is the pain:	
Sharp?	O
Dull?	O
Burning?	O
Does the pain:	
Radiate?	O
Where?	
Since the pain started, is it getting:	
Better?	O
Same?	O
Worse?	O

Which activities aggravate your condition?
Is this condition interfering with any of the following? Work O Sleep O Daily Routine O Sports/exercise O Other (please explain) O
Who else, if anyone, have you seen regarding this condition?

GENERAL HEALTH HISTORY

Often unexpected or seemingly unrelated stresses on our bodies can lead to health problems and influence our ability to heal. Please answer the following section as thoroughly and honestly as possible.

Have you had surgery or any major traumas?	
Type:	When?:
Type:	When?:

Do you wear orthotics or heel lifts?	

Past Medical History

Please mark the conditions you currently have or have had in the past		
o Allergies	o Digestive issues	o Miscarriage(s)
o Anxiety	o Gout	o Multiple Sclerosis
o Atherosclerosis	o Headaches	o Sinus problems
o Arthritis	o Heart attack	o Sciatica
o Asthma	o Heart disease	o Scoliosis
o Back pain	o High blood pressure	o Stroke
o Cancer	o Irregular periods	o Tinnitus
o Depression	o Low blood pressure	o Other: _____
o Diabetes	o Migraines	

Please List any medications or supplements that you currently take:			
1.	2.	3.	4.
5.	6.	7.	8.

On a scale of 0 to 10, please grade your current level of stress (0 being no stress, 10 being extremely stressed)		
At work:	At home:	At play:

On a scale of 0 to 10, please describe your (0 being poor, 10 being perfect)				
Eating habits:	Exercise habits:	Sleep:	Gen. health:	Mindset:

What are your short term health goals?

What are your long term health goals?

At Complete Care Chiropractic, we aim to create a comfortable and therapeutic environment for our clients to ensure the optimal results from their care. If any aspect of your experience at Complete Care does not meet your expectations, please raise your concerns with your chiropractor or chiropractic assistant immediately.

I hereby request and consent to the performance of chiropractic procedures, including various modes of chiropractic treatment, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:

Signature: _____ Date:

Doctor of Chiropractic:

Signature: _____ Date: