LIFE CHIROPRACTIC

Bruce D. Stevens D.C.
217-A West Central, Lompoc CA 93436 • 805-737-5656
www.lifechirolompoc.com

Name: ____ Male Female

Address: ____

City: ___________________________________ State: _________ Zip: ________

Home Phone: ___________________________ Cell Phone: __________________________

E-mail Address: ____

Date of Birth: ____________________________ SSN: ______________________________

Single Married Divorced Widow Number of Children __________

Are you pregnant Yes No

Height: ___________Weight: ___________

How were you referred to our office? _______________________________________

Have you ever had chiropractic care before? Yes No

If yes, when and where and what did you like or not like about your previous care?

____

____

Employer: ____

Address: ____

City: _________________________________ State: _________ Zip: ______________

Work Phone: _________________________ Ext: ____________

Are you covered by health insurance? Yes No

**If yes, please give your card to the Front Desk so they may get a copy.*

Is this injury work related? Yes No

Is this injury a result of an Auto Accident? Yes No

**If you answered yes to either of the above questions please let the Front Desk know immediately.*

Please list your chief complaints in order of severity (pain, symptoms, etc)

1. ____ For how long? ___________

How has this complaint limited or affected any of your daily activities (like exercise, house cleaning, work or sleep? Example: I can only sit for 15 minutes and then the pain increases.

____

2. ____ For how long? ___________

How has this complaint limited or affected any of your daily activities?

____

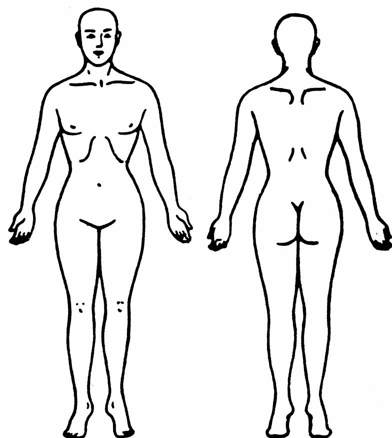
3. ____ For how long? ___________

How has this complaint limited or affected any of your daily activities?

____

Complete Diagram Below

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe they type and frequency of your pain, as well as any activity that brings on or aggravates the pain. For example, is dull, sharp, constant, off and on, when standing, when sitting etc.



=== **Dull pain**

x x x **Sharp pain**

+ + + **Burning**

o o o **Numbness/ tingling**

Please list other doctors consulted for this condition: N/A

1. ____
2. ____

How did this condition develop? What caused it? (fall, lifting, etc)

____

____

Date of injury: ____________ Has this problem been getting Better Worse Staying the same

Is there anything you do that makes your condition worse? Yes No

If yes, please list: ____

Have you ever had any surgery/hospitalizations? Yes No

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If yes, please list: ____

Please list injuries or illness that you have had in the past that are not listed above: Example cancer, diabetes, arthritis etc.

____

Medication you now take   Aspirin/Tylenol   Painkillers   Muscle Relaxers

Tranquilizers   Insulin   Birth Control Pills

Other (please list) ____

Family History: Do you have a family history of heart disease, cancer, arthritis? _________________

____

Do you smoke or use Tobacco Products?   Yes   No If yes what and how often? ______________

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal: to detect and correct/reduce the vertebral subluxation complex. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae in the spinal column which caused alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat disease or a condition other than vertebral subluxation. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.

Method of payment you plan to use for today's charges: Check   Cash   Credit Card   Special

1. All first-visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for the purpose of analysis, they cannot be released.

NOTE: It is understood and agreed the amount paid to Life Chiropractic for x-rays for examination only and the x-ray negatives will remain the property of this office, being on the file where they may be seen at any time while a patient of this office. Not all patients require x-rays to determine or verify a diagnosis, type of length of treatment. If your examination warrants x-ray analysis, the preceding office policy prevails.

Patient Signature: ____ Date: _________

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, 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, 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. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

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.

Name of Patient:____

Signature of Patient:____

Name Printed of Guardian/Parental and Relationship to Patient:______________________________

Guardian/Parental Signature:____

Date:_________________________

Doctor of Chiropractic Name: Bruce D. Stevens, D.C.

Signature of Doctor of Chiropractic:____

Date:____________________