COVID 19 INFORMATION &LIABILITY WAIVER

Client Name: _____ Date: _____

COVID –19 Information

1. Have you had a fever in the last 24 hours of 100° F or above? Yes☐ No☐

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes☐ No☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus-type symptoms? Yes☐ No☐

Consent for Treatment

I understand that, because Chiropractic Treatment involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntary agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____ Date: _____

Parent or Guardian signature (in case of minor): _____ Date: _____

HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
01 02 03 04 05 06 07 08 09 10 11 12	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	00 01 02 03 04 05 06 07 08 09 10 20 30 40 50 60 70 80 90

DR# PATIENT NUMBER

NO MARKS HERE

A. PATIENT INFORMATION

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth Age

Sex: ⬭ Male ⬭ Female

Marital Status:
⬭ Single ⬭ Married ⬭ Widowed ⬭ Divorced ⬭ Other

Patient Resides With:
⬭ Lives Alone ⬭ Spouse ⬭ Parents ⬭ Children ⬭ Other

Children:
⬭ Yes ⬭ No How Many? 1 2 3 4 5+

Spouse

Name

Social Security #

NO MARKS HERE

B. COMPLAINTS

1. What Are Your Primary Complaints? ⬭ *None*

	LEFT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		RIGHT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

2. What Are Your Secondary Complaints? ⬭ *None*

	LEFT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		RIGHT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

3. Additional Complaints? ⬭ Yes ⬭ No Please List:

4. When Did Your Symptoms Begin?
⬭ Date

5. How Often Do Your Symptoms Occur?
⬭ Occasional ⬭ Intermittent ⬭ Frequent ⬭ Constant ⬭ Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

NO MARKS HERE

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PLEASE MAKE NO MARKS IN THIS AREA

B. COMPLAINTS (CONTINUED)

7. Are You Getting? ○ Better ○ Worse ○ Same

8. If Your Complaints Include Pain, Is It Aggravated By?

○ Coughing	○ Reaching	○ Standing
○ Sneezing	○ Lifting	○ Walking
○ Straining At Stool	○ Bending	○ Other
○ Neck Movement	○ Sitting	

9. If Your Complaints Include Pain, Is It Relieved By?

○ Nothing	○ Heat	○ Sitting
○ Rest	○ Stretching	○ Standing
○ Ice	○ Exercise	○ Other

10. Have You Had Recent Treatment For This Condition?
○ Yes ○ No If Yes, List Dates, Treatments, And Doctors:

11. Has This Condition Existed In The Past? ○ Yes ○ No

12. Since Your Symptoms Began, Have You Noticed A Change In? If Yes, Indicate

	Onset Date	Duration
○ Bowel Function		
○ Bladder Function		
○ Sexual Function		

NO MARKS HERE

C. REVIEW OF SYSTEMS

1. Are You Currently Suffering From Any Of The Symptoms Listed Below?

a. General

○ Normal	
○ Fatigue	○ Chills
○ Weakness	○ Weight Change
○ Fever	○ Night Sweats
○ Loss Of Sleep	○ Other

b. Skin

○ Normal	○ Eczema
○ Rash	○ Hair Changes
○ Redness	○ Nail Changes
○ Itching	○ Bruise Easily
○ Dryness	○ Other

c. Neurologic

○ Normal	○ Convulsions
○ Headache	○ Nervousness
○ Dizziness	○ Other
○ Fainting	

d. Eyes

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

Right
Left

e. Ears

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

Right
Left

f. Nose

○ Normal	○ Infections
○ Pain	○ Absence Of Smell
○ Bleeding	○ Other
○ Sinus Problems	

g. Mouth/Throat

○ Normal	○ Absence Of Taste
○ Sores	○ Abnormal Taste
○ Bleeding	○ Tonsilitis
○ Enlarged Glands	○ Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)

○ Normal	○ Varicosities
○ Cough	○ Murmur
○ Wheezing	○ Chest Pain
○ Difficulty Breathing	○ Palpitations
○ Swollen Extremities	○ Other
○ Blue Extremities	

i. Breasts

○ Normal	○ Dimpling
○ Lumps In Breast(s)	○ Discharge
○ Redness/Itching	○ Other
○ Pain	

j. Gastrointestinal (Stomach/Digestion)

○ Normal	○ Excess Gas
○ Decreased Appetite	○ Vomiting
○ Increased Appetite	○ Diarrhea
○ Abdominal Pain	○ Constipation
○ Hemorrhoids	○ Other

k. Genitourinary

○ Normal	○ Painful Menstruation
○ Inability To Hold Urine	○ Abnormal Vaginal Bleeding
○ Painful Urination	○ Impotence
○ Frequent Urination	○ Sterility
○ Bedwetting	○ Prostate Problems
○ Irregular Menstruation	○ Other

l. Endocrine (Metabolism)

○ Normal	○ Goiter
○ Heat/Cold Intolerance	○ Tremor
○ Sugar In Urine	○ Other

mPsychologic

○ Normal	○ Phobias
○ Anxiety	○ Mood Swings
○ Depression	○ Other
○ Memory Loss Or Impairment	

NO MARKS HERE

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NO MARKS HERE

C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1. _____	○	○	○
2. _____	○	○	○
3. _____	○	○	○

3. What Are Your Habits?

	Never	<1	1-2	2-3	3-4	5+
			Packs/Day			
Smoking	○	○	○	○	○	○
			Drinks/Day			
Alcohol	○	○	○	○	○	○
			Cups-Glasses/Day			
Caffeinated Drinks	○	○	○	○	○	○
			Days/Week			
Exercise	○	○	1-2 ○	3-4 ○	5-6 ○	7 ○

Drug/Substance Abuse — Never ○ Yes ○ If Yes, Discuss With Doctor

NO MARKS HERE

D. MEDICAL HISTORY

1. Health Care

a. **Have You Been To A Chiropractor** ..... Yes ○ No ○

b. **Do You Have A Family Physician** ..... Yes ○ No ○

Date Of Last Physical Exam _____

Physician's Name & Address _____

c. **Have You Been Hospitalized In The Past Five Years** ..... Yes ○ No ○

Date & Reason For Hospitalization _____

d. **Have You Had Surgery In The Past Five Years** ..... Yes ○ No ○

Date & Reason For Surgery _____

e. **Have You Had A Serious Accident In The Past Five Years** ..... Yes ○ No ○

○ Auto ○ Work ○ Home ○ Other _____

List Date & Describe Injury _____

f. **Do You Have Any Drug Allergies** ..... Yes ○ No ○

List Drugs _____

g. **Are You Currently Taking Any Medication** . Yes ○ No ○

○ Anti-inflammatory (Aspirin, Motrin, etc.)
○ Muscle Relaxants ○ Pain Medication/Analgesic
○ Tranquilizers ○ Antibiotics
○ Blood Pressure Pills ○ Other
○ Birth Control Pills

For What Condition/s Are You Taking Medication? _____

NO MARKS HERE

h. **WOMEN ONLY:**

To Your Knowledge Are You Pregnant .... Yes ○ No ○

Have Your Past Pregnancies Been Normal . Yes ○ No ○

Are You Seeing An OB-GYN Regularly .... Yes ○ No ○

Date Of Last Exam _____

Physician's Name & Address _____

2. If you now have or you have had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

○ ***No Previous Conditions/Illnesses***

Now Have	Have Had		Now Have	Have Had	
NH ○	HH ○	Arthritis	NH ○	HH ○	Sexually Transmitted Disease
NH ○	HH ○	Asthma	NH ○	HH ○	Ulcer
NH ○	HH ○	Sinus Trouble	NH ○	HH ○	Cancer
NH ○	HH ○	Hay Fever	NH ○	HH ○	Polio
NH ○	HH ○	Allergies	NH ○	HH ○	Rheumatic Fever
NH ○	HH ○	Tuberculosis	NH ○	HH ○	Serious Injury
NH ○	HH ○	Diabetes	NH ○	HH ○	Bone Fracture
NH ○	HH ○	Epilepsy	NH ○	HH ○	Dislocated Joints
NH ○	HH ○	Thyroid Trouble	NH ○	HH ○	Spinal Disc Disease
NH ○	HH ○	High Blood Pressure	NH ○	HH ○	Multiple Sclerosis
NH ○	HH ○	Low Blood Pressure	NH ○	HH ○	Scoliosis
NH ○	HH ○	Heart Trouble	NH ○	HH ○	Mental/Emotional Difficulty
NH ○	HH ○	Pacemaker	NH ○	HH ○	Prostate Trouble
NH ○	HH ○	HIV/ARC	NH ○	HH ○	Kidney Trouble
NH ○	HH ○	AIDS	NH ○		Other _____
				HH ○	Other _____

3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture	Present Age or Age at Death	Deceased
Father	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Mother	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

○ Full Time ○ Temporary
○ Part Time ○ Other _____

2. Work Week

Hours Per Day: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○

Days Per Week: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

○ Other _____

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day ○ Yes ○ No

4. Length Of Time At Present Occupation

Years: 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○

Months: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○

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E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)

5. **Job Involves**
   a. **Lifting** ..... ○10 ○20 ○30 ○40 ○50 ○60 ○70 ○80 ○90 ○100+ Pounds
   ○ Never ○ Frequently
   ○ Occasionally ○ Constantly

   b. **Additional Job Requirements**
   ○ Bending ○ Twisting ○ Carrying
   ○ Stooping ○ Turning ○ Walking
   ○ Other

6. **What Is Your Primary Work Position \ Location?**
   a. Position:
   ○ Seated
   ○ Standing
   ○ Other
   b. Location:
   ○ Desk ○ Counter
   ○ Workbench
   ○ Other

   c. If Seated, What Type Of Chair Do You Use?
   ○ Executive ○ Steno ○ Bench
   ○ Stool ○ Other

7. **Do You Wear Shoes Or Boots With High Heels?**
   ○ Never ○ Seldom ○ Occasionally ○ Frequently

8. **Are You Right Or Left Handed?**
   ○ Right ○ Left

9. **Do Work Activities Aggravate Your Present Complaints?**
   ○ Yes ○ No

10. **Which Of The Following Best Describes Your Stress Level?**
    ○ None ○ Minimal ○ Moderate ○ Great

11. **How Do You Rate Your Physical Activity At Work?**
    ○ Seated more than 50% of workday
    ○ Light Manual Labor
    ○ Moderate Manual Labor
    ○ Heavy Manual Labor

F. INSURANCE INFORMATION

1. **Is Your Condition Due To:**
   An Automobile Accident ..... Yes ○ No ○
   A Personal Injury ..... ○ ○
   A Job Injury ..... ○ ○

2. **Do You Have Health Insurance** ..... Yes ○ No ○
   Company
   Policy #

3. **Is Your Spouse Employed.** ..... Yes ○ No ○
   Business
   Address

4. **Is Your Spouse The Primary Insured** ..... Yes ○ No ○
   Company
   Policy #

5. **HMO, PPO Plan Coverage** ..... Yes ○ No ○
   Company
   Policy #

6. **Are You Covered By Medicare** ..... Yes ○ No ○
   Medicare #

7. **Authorization To Release Records To Patient's Insurance Carrier**
   Patient or Guardian's Signature

G. PAYMENT

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 PAYING TODAY BY: (If paying by credit card please confirm which cards are accepted by our office.)
○ Cash ○ Check ○ Visa
○ MasterCard ○ DiscoverCard ○ American Express
○ Other

Account #
Expiration Date

Patient's Signature Date

Guardian or Spouse's Signature Date

Doctor's Signature Date

Is There Anything Else You Would Like Us To Know?
○ Yes ○ No

NO MARKS HERE

1198599
PLEASE MAKE NO MARKS IN THIS AREA

AUTOMOBILE CRASH QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

A. VEHICLE YOU WERE IN

1. Vehicle type?
○ Car ○ Pickup ○ Van ○ Truck ○ Station Wagon ○ Bus ○ Other

2. Vehicle size?
○ Subcompact ○ Full-Size ○ Compact ○ Mini ○ Mid-Size ○ Light ○ Other

3. What was your location in the vehicle?
○ Driver ○ Front Passenger ○ Rear Passenger
Passenger Location: ○ Left ○ Middle ○ Right
○ Other

4. What was the vehicle you were in doing?
Mark only ONE bubble below to answer this question

a. Vehicle stopped for
○ Traffic Light ○ Intersection ○ Stop Sign ○ Traffic ○ Pedestrian ○ Parked ○ Other

b. Vehicle slowing down for
○ Traffic Light ○ Intersection ○ Stop Sign ○ Traffic ○ Pedestrian ○ Turning ○ Parking ○ Other

c. Vehicle moving
○ Slowly ○ Moderately ○ Fast ○ ____ MPH ○ Accelerating ○ Other

d. Vehicle doing other
○ Other

5. What damage did the vehicle you were in sustain?
○ Minimal ○ Moderate ○ Extensive ○ Totaled ○ Unsure ○ Other

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?
○ Car ○ Pickup ○ Van ○ Truck ○ Station Wagon ○ Bus ○ Other

b. Vehicle size?
○ Subcompact ○ Full-Size ○ Compact ○ Mini ○ Mid-Size ○ Light ○ Other

c. How did this vehicle strike the vehicle you were in?
○ Head On ○ From Right ○ From Left ○ Rear Ended ○ Sideswiped On Right ○ Sideswiped On Left ○ Other

d. What damage did this vehicle sustain?
○ Minimal ○ Moderate ○ Extensive ○ Totaled ○ Unsure ○ Other

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?
○ Car ○ Pickup ○ Van ○ Truck ○ Station Wagon ○ Bus ○ Other

b. Vehicle size?
○ Subcompact ○ Full-Size ○ Compact ○ Mini ○ Mid-Size ○ Light ○ Other

c. How did this vehicle strike the vehicle you were in?
○ Head On ○ From Right ○ From Left ○ Rear Ended ○ Sideswiped On Right ○ Sideswiped On Left ○ Other

d. What damage did this vehicle sustain?
○ Minimal ○ Moderate ○ Extensive ○ Totaled ○ Unsure ○ Other

3. Describe Other Vehicles To Strike Vehicle You Were In
○ Vehicle Type: ○ How it struck:
○ Vehicle Size: ○ Damage:

4. Were traffic citations issued as a result of the accident?
○ No Citations issued ○ Driver Of Other Vehicle ○ Driver Of Vehicle You Were In ○ You ○ Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?
○ Daylight ○ Dawn ○ Dusk ○ Night ○ Other

2. What was the condition of the road?
○ Dry ○ Damp ○ Wet ○ Snow Covered ○ Icy ○ Other

3. Visibility

a. What was the visibility at impact?
○ Good ○ Fair ○ Poor ○ Other

b. If visibility was poor, why?
○ Sun Light ○ Darkness ○ Rain ○ Snow ○ Fog ○ Traffic ○ Other

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PLEASE MAKE NO MARKS IN THIS AREA

D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

○ Accident A Complete Surprise
○ Aware Of Impending Collision ○ And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? ○ Yes ○ No

b. Was it knocked off pedal by impact? ○ Yes ○ No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? ○ Yes ○ No

2. What type of restraint belt were you wearing?
○ Shoulder-Lap Belt ○ Shoulder Belt ○ Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? ○ Yes ○ No

2. What position was the headrest in?
○ Low ○ Middle ○ High ○ Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?
○ Yes ○ No ○ Unsure

2. Did the air bags deploy? ○ Yes ○ No

4. Your Body

a. What was your body position at impact?
○ Straight ○ Slouched Forward **Rotated:** ○ Right ○ Left
○ Don't Recall ○ Other

b. What direction was your body thrown?
○ Forward\Backward ○ Backward\Forward ○ Sideways
○ Across Vehicle ○ Outside Vehicle ○ Under Vehicle
○ Don't Recall ○ Other

5. Your Head And Neck

a. What position were your head/neck in at impact?
○ Straight ○ Tilted Forward **Rotated:** ○ Right ○ Left
○ Don't Recall ○ Other

b. Through what motion were your head/neck pitched?
○ Forward\Backward ○ Backward\Forward ○ Sideways
○ Don't Recall ○ Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

b. Right Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

c. Left Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

d. Torso

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

e. Right Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

f. Left Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

2. Did your body strike any other objects?

○ Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

○ Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: **Date:**

ACCIDENT / INJURY QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

A. DATE AND TIME OF ACCIDENT / INJURY

○ Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

○ Automobile Crash Questionnaire Marked **(Skip Section B)**
○ Workmen's Compensation Accident / Injury
○ Slip/Fall Accident ○ Pedestrian Accident
Other: ○ Accident ○ Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?
○ Yes ○ No ○ Don't Know

2. How did you feel?
○ Confused ○ Dazed ○ Dizzy ○ Nervous
○ Weak ○ Other

3. Where did you immediately develop pain?

○ Head	ⓇⓁ Shoulders	ⓇⓁ Buttocks
○ Neck	ⓇⓁ Arms	ⓇⓁ Hips
○ Upper / Mid Back	ⓇⓁ Elbows	ⓇⓁ Thighs
○ Lower Back	ⓇⓁ Forearms	ⓇⓁ Knees
○ Pelvis	ⓇⓁ Wrists	ⓇⓁ Legs
○ Chest / Rib Cage	ⓇⓁ Hands	ⓇⓁ Ankles
○ Abdomen		ⓇⓁ Feet
○ Other		

4. If there were lacerations (cuts), where were they?

○ Head	ⓇⓁ Shoulders	ⓇⓁ Buttocks
○ Neck	ⓇⓁ Arms	ⓇⓁ Hips
○ Upper / Mid Back	ⓇⓁ Elbows	ⓇⓁ Thighs
○ Lower Back	ⓇⓁ Forearms	ⓇⓁ Knees
○ Pelvis	ⓇⓁ Wrists	ⓇⓁ Legs
○ Chest / Rib Cage	ⓇⓁ Hands	ⓇⓁ Ankles
○ Abdomen		ⓇⓁ Feet
○ Other		

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site
a. Did you receive emergency care? ○ Yes ○ No

b. What type of emergency care did you receive?
○ Bandages ○ Splints ○ Brace ○ Neck Collar
○ Other

7. Destination After Accident / Injury

a. Where did you go?
○ Hospital ○ Home
○ School ○ Work
○ Other

b. By whom were you driven?
○ Myself ○ Ambulance
○ Friend ○ Family Member
○ Other

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?
○ Immediately ○ Later That Day ○ Next Day ○ Days Later
○ Date / / ○ Other

○ Hospital Name:
○ Examined By Doctor:

Admitted: ○ Yes ○ No ○ Date Discharged: / /

2. If x-rays were taken, of what body part(s)?

○ Head	ⓇⓁ Shoulders	ⓇⓁ Buttocks
○ Neck	ⓇⓁ Arms	ⓇⓁ Hips
○ Upper / Mid Back	ⓇⓁ Elbows	ⓇⓁ Thighs
○ Lower Back	ⓇⓁ Forearms	ⓇⓁ Knees
○ Pelvis	ⓇⓁ Wrists	ⓇⓁ Legs
○ Chest / Rib Cage	ⓇⓁ Hands	ⓇⓁ Ankles
○ Abdomen		ⓇⓁ Feet
○ Other		

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E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

○ Anxiety	○ Convulsions	○ Restlessness
○ Depression	○ Dizziness	○ Insomnia
○ Mood Swings	○ Headaches	○ Light Sensitivity
○ Nervousness	○ Fainting	○ Reduced Appetite
○ Poor Memory	○ Loss Of Balance	○ Weakness
○ Tension	○ Fatigue	○ Weight Gain
○ Other		○ Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

○ Daily Living ○ Occupational/Work ○ Recreational Activities
○ Other

6. Have you missed work due to this accident / injury?

○ Missed No Work ○ Limited Work Activity
○ Missed Work From: / / To: / /
○ Other

7. Did you self treat your symptoms?

○ Ice ○ Heat ○ Bed Rest ○ Over-The-Counter Medication
○ Other

8. Did you seek medical care elsewhere?

a. General Practitioner ○ Name:
○ Diagnosis And Treatment Recommendation:

b. Internist ○ Name:
○ Diagnosis And Treatment Recommendation:

c. Chiropractor ○ Name:
○ Diagnosis And Treatment Recommendation:

d. Neurologist ○ Name:
○ Diagnosis And Treatment Recommendation:

e. Orthopedist ○ Name:
○ Diagnosis And Treatment Recommendation:

f. General Surgeon ○ Name:
○ Diagnosis And Treatment Recommendation:

g. Plastic Surgeon ○ Name:
○ Diagnosis And Treatment Recommendation:

h. Psychologist ○ Name:
○ Diagnosis And Treatment Recommendation:

i. Other ○ Name: ○ Type:
○ Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

○ CT Scan ○ MRI ○ Electrodiagnostic Studies
○ Other

10. What is the reason for seeking today's consultation?

○ Persisting Complaints ○ Worsening Of Symptoms
○ Other

F. INSURANCE / ATTORNEY INFORMATION

	Yes	No
1. Have you contacted an insurance adjuster or representative regarding this claim?	○	○
Company:		
Adjuster:		
Claim #:		
2. Have you engaged services of an attorney?	○	○
Attorney:		
Address:		
City: **State:** **Zip:**		
Phone:		
3. Have you filed an accident / injury report?	○	○
4. Have you filed for insurance benefits?	○	○

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Patient's Or Guardian Signature: **Date:**

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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER
	12	17		

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities.

Please answer **each section** by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which closely describes your problem now.**

Please use a **No. 2 pencil** to fill in your answer.
Fill in bubbles **completely** as indicated here: ⬭
Erase changes cleanly. Do **not fold** this form.

1. PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

2. PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

3. LIFTING

- I can lift heavy weights, without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

4. READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

5. HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

After Vernon & Mior, 1991
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6. CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

7. WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

8. DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

9. SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

10. RECREATION

- I am able to engage in all of my recreational activities, with no neck pain at all.
- I am able to engage in all of my recreational activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

SIGNATURE: _____ **DATE:** _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER

From: N.Hudson, K. Tome-Nicholson, A Breen; 1989
Revised 09/11/92

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities.

Please answer each section by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which most closely describes your problem right now.**

Please use a **No. 2 pencil** to fill in your answers.
Fill in bubbles **completely** as indicated here: ⬭
Erase changes cleanly. Do **not fold** this form.

1. PAIN INTENSITY

- Ⓐ The pain comes and goes and is very mild.
- Ⓑ The pain is mild and does not vary much.
- Ⓒ The pain comes and goes and is moderate.
- Ⓓ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is severe.
- Ⓕ The pain is severe and does not vary much.

2. PERSONAL CARE

- Ⓐ I would not have to change my way of washing or dressing in order to avoid pain.
- Ⓑ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓒ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Ⓓ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain, I am unable to do some washing and dressing without help.
- Ⓕ Because of the pain, I am unable to do any washing or dressing without help.

3. LIFTING

- Ⓐ I can lift heavy weights without extra pain.
- Ⓑ I can lift heavy weights, but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor.
- Ⓓ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e. g., on a table.
- Ⓔ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- Ⓕ I can only lift very light weights, at the most.

4. WALKING

- Ⓐ Pain does not prevent me from walking any distance.
- Ⓑ Pain prevents me from walking more than one mile.
- Ⓒ Pain prevents me from walking more than 1/2 mile.
- Ⓓ Pain prevents me from walking more than 1/4 mile.
- Ⓔ I can only walk while using a cane or on crutches.
- Ⓕ I am in bed most of the time and have to crawl to the toilet.

5. SITTING

- Ⓐ I can sit in any chair as long as I like without pain
- Ⓑ I can only sit in my favorite chair as long as I like.
- Ⓒ Pain prevents me from sitting more than one hour.
- Ⓓ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than ten minutes.
- Ⓕ Pain prevents me from sitting at all.

6. STANDING

- Ⓐ I can stand as long as I want without pain.
- Ⓑ I have some pain while standing, but it does not increase with time.
- Ⓒ I cannot stand for longer than one hour without increasing pain.
- Ⓓ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than ten minutes without increasing pain.
- Ⓕ I avoid standing, because it increases the pain straight away.

7. SLEEPING

- Ⓐ I get no pain in bed.
- Ⓑ I get pain in bed, but it does not prevent me from sleeping well.
- Ⓒ Because of pain, my normal night's sleep is reduced by less than one-quarter.
- Ⓓ Because of pain, my normal night's sleep is reduced by less than one-half.
- Ⓔ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Ⓕ Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- Ⓐ My social life is normal and gives me no pain.
- Ⓑ My social life is normal, but increases the degree of my pain.
- Ⓒ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Ⓓ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓕ I have hardly any social life because of the pain.

9. TRAVELING

- Ⓐ I get no pain while traveling.
- Ⓑ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- Ⓒ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- Ⓓ I get extra pain while traveling which compels me to seek alternative forms of travel.
- Ⓔ Pain restricts all forms of travel.
- Ⓕ Pain prevents all forms of travel except that done lying down.

10. CHANGING DEGREE OF PAIN

- Ⓐ My pain is rapidly getting better.
- Ⓑ My pain fluctuates, but overall is definitely getting better.
- Ⓒ My pain seems to be getting better, but improvement is slow at present.
- Ⓓ My pain is neither getting better nor worse.
- Ⓔ My pain is gradually worsening.
- Ⓕ My pain is rapidly worsening.

SIGNATURE: _____ DATE: _____

MEDICAL ASSIGNMENT AND RECORDS RELEASE

AUTHORIZATION AND ASSIGNMENT

I, _____ agree to the following:
(Patient's Name)

1. I hereby authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. 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.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me.

_____ _____
(Patient's Signature) (Date)

RECORDS RELEASE

I hereby authorize you to release any information including the diagnosis and records of any examination or treatment rendered to me to the following person(s):

_____

Effective dates for this authorization:___/___/_____ through___/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

Denise Soliz _____ _____
Authorized Facility Representative Date

Patient Name: _____ **Date of Birth**: _____

Social Security # _____ **Date**: _____

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologist, chiropractors, dentist, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any care risk, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risk and/or complications. Informed consent information regarding and risk such as paraplegia, quadriplegia, brain damage, stroke, disc injury breaks, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduated chiropractors who are licensed and recognized by government agencies regulating all the aforementioned health arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.) Adjustments are made by chiropractors to correct and/or reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risk. With C.M.T.'s these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risk, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding

the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Patient Name Printed	Patient Signature	Date
Patient/Guardian Signature (if minor)	Denise Soliz Doctor/ Witness Name Printed	Date

Arbitration Agreement
Physician/Patient Out-Patient Form

Arbitration is a way to decide health care complaints without going to court.

By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about chiropractic care. This agreement only applies to the care that I receive in this office during the next year from undersigned chiropractor, associated or any office assistant or substitutes, employed by or assigned to my care by my chiropractor immediately following the execution of this form or during the time when this form is in effect. This agreement does not apply to disagreements over the fees charged.

State law gives me a choice of two ways to decide claims; either a trail by a judge, or by arbitration. I have a right to a lawyer for a trial or arbitration.

If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a Doctor of Chiropractic. My doctor(s) and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association and my doctor's state or national association representative may appoint the panel member. State laws and the rules of the American Arbitration Association will apply to all arbitration hearings and may vary from state to state. All parties are delegated to investigate on their own and/or seek counsel.

I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives. This agreement also applies to any professional corporation or partnership that my doctor belongs to or works for. If I want to change my mind and cancel this agreement, I must notify my doctor in writing within 60 days after I sign. After 60 days, I cannot change my decision unless mutually agreed upon by all parties.

In most cases, a decision by an arbitration panel is final and cannot be appealed.

Delta Chiropractic Clinic Offered by:	Patient Name Printed	
Denise Soliz Signature of Chiropractic	Patient Signature	Date

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLED.

Parent/Guardian/Legal Representative Signature: _____ Date:_____