BEAVERTON FAMILY CHIROPRACTIC

This is the intake paperwork for your first visit with the doctor
Please Print SINGLE Sided
Please use a BLUE or BLACK INK PEN

Here are some helpful hints to make filling out your paperwork easier for you:

- Filling out your paperwork completely ***before*** coming into the office will allow the most time with the doctor.
- Fill out the information about your reason for seeing the doctor on the ***day of your appointment***, so the information is as current as possible. (History information can be completed any time.) ***Leave the signature and dates lines blank - you will complete these in the office on the day of your first visit.***
- Each line/blank should have an answer. If a question does not apply please write N/A or put a line through it.
- You will notice the last pages are to document any specific symptoms you may have. There are enough pages to describe 6 separate symptoms. If you need more pages, please make copies of the last page before filling it out.

If you have any questions feel free to call 503.644.8844, or email us at
BFC@BeavertonFamilyChiropractic.com
We are here to help you!

Your health is our primary concern!
Thank you for choosing us to help you on your path to greater health.

We look forward to serving you!

Your Beaverton Family Chiropractic Health Care Team!

Our Mission

To transform lives in our community today, tomorrow and for generations to follow with Hope, Love, and Service

Beaverton Family Chiropractic, PC - 5075 SW Griffith Drive, Suite 120 - Beaverton, Oregon 97005
www.BeavertonFamilyChiropractic.com - BFC@BeavertonFamilyChiropractic.com
503.644.8844 Office

APPLICATION FOR CARE AT BEAVERTON FAMILY CHIROPRACTIC, PC

PATIENT DEMOGRAPHICS

ID #: _____

Legal Name: _____ Date of Birth: ____ - ____ - ____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Marital Status: S M D W O

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Names and Ages of your children: _____

Name & Number of Emergency Contact: _____ Relationship: _____

☐ Name of Most Recent Chiropractor: _____ ☐ Never been to a chiropractor

Who may we thank for referring you to this office? _____

REASON(S) FOR SEEKING CARE IN OUR OFFICE:

On a scale from 0 to 10, with 10 being the worst pain and 0 being no pain, rate your complaints by circling the number:

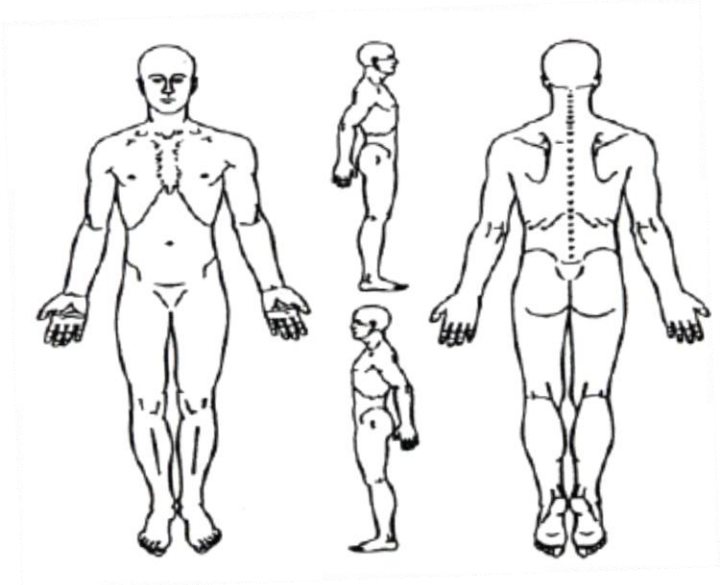
Primary Condition: _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary Condition: _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is this a result of an accident or injury? ☐ Yes ☐ No

*PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/ Stabbing
T= Tingling
O = Other: _____



What activities have been restricted?	PREVIOUS activity level?	CURRENT activity level?
Ex: *Sleep*	*8 hours of restful sleep*	*2-3 hours of restless sleep*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

_____ _____ _____ - _____ - _____

Patient or Authorized Person's Signature | Patient Initials | Date Completed

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

CURRENT HEALTH HISTORY – *CONTINUED*

Other/Previous interventions, treatments, medications, surgery, or care you've sought for your current complaint(s):

_____

_____

PAST HEALTH HISTORY

Have you suffered with this or a similar problem in the past? ☐ No ☐ Yes If Yes how many times? _____

When was the last episode? _____ How did the injury happen? _____

Previous Injury or Trauma: (EX. Work Injury, Auto Collision, Trip/Fall, Childhood Injury) ☐ None

_____

Have you ever broken any bones? ☐ No ☐ Yes Which? _____

Allergies: _____ ☐ None

List Prescription & Non-Prescription drugs you take: ☐ None

Drug	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries: ☐ None

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females – Pregnancies and outcomes: ☐ None

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

Anything else in your past health history that you feel is important to your care here?

_____

_____

_____

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

REVIEW OF SYSTEMS

Have you had any **pulmonary (lung-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **cardiovascular (heart-related)** issues or procedures? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **neurological (nerve-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **endocrine (glandular/hormonal)** related issues or procedures? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **renal (kidney-related)** issues or procedures? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **gastroenterological (stomach-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **hematological (blood-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **dermatological (skin-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **musculoskeletal (bone/muscle-related)** issues? ☐ **No**

☐ If **Yes**, describe: _____

Have you had any **psychological** issues? ☐ **No**

☐ If **Yes**, describe: _____

FAMILY HEALTH HISTORY

Do any of your family suffer with the same condition(s)? ☐ **No** ☐ **Yes**

If yes whom: _____

Any other hereditary conditions the doctor should be aware of? ☐ **No** ☐ **Yes**

If yes, please describe: _____

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

SOCIAL HEALTH HISTORY

Smoking: ❑cigars ❑ pipe ❑ cigarettes ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

Alcoholic Beverage: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

CURRENT/PAST

Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

IDENTIFY TYPE:	EFFECT:			
_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

◆◆◆◆◆

I hereby authorize payment to be made directly to Beaverton Family Chiropractic, PC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Beaverton Family Chiropractic, PC for any and all services I receive at this office.

_____ _____ _____ - _____ - _____

Patient or Authorized Person's Signature | Patient Initials | Date Completed

For Doctor Use Only:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Legal Name: _____ DOB: _____ - _____ - _____ ID #: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck			Low Back			
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

ACTIVIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carrying Bag/purse/briefcase	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving (Face – Legs)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stepping up and/or over curb	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting/Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Relationships	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

Primary Condition _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the condition most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above condition at the above intensity:
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did the condition begin? _____
- Did the condition begin suddenly or gradually? (circle one) How did the symptom begin? _____
- What makes the condition worse? _____
- What makes the condition better? _____
- Describe the quality of the condition (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the condition radiate to another part of your body (circle one): ☐ No ☐ Yes
  - If yes, where does the symptom radiate? _____
- Is the condition worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

Secondary Condition _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the condition most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above condition at the above intensity:
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did the condition begin? _____
- Did the condition begin suddenly or gradually? (circle one) How did the symptom begin? _____
- What makes the condition worse? _____
- What makes the condition better? _____
- Describe the quality of the condition (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the condition radiate to another part of your body (circle one): ☐ No ☐ Yes
  - If yes, where does the symptom radiate? _____
- Is the condition worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ DOB: _____ - _____ - _____ ID #: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

FEMALES ONLY: *Please read carefully and initial the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, please see the front desk for further explanation.*

REGARDING: X-rays/Imaging Studies

☐ The first day of my last menstrual cycle was on: ____/____/____
Date

☐ I understand that I am most likely to become pregnant between ten to twelve days after the start date of my menstrual cycle. To the best of my knowledge I am not pregnant.

☐ Not Applicable

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Patient's Legal Name: _____ DOB: _____ - _____ - _____ ID #: _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Beaverton Family Chiropractic, PC we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not available at home and/or work to receive an appointment reminder, a message may be left for you. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time, separated by a partition. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of ***April 14, 2003***. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice. **If you have a question, or complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your concerns to:** ***Daniel P. Miller, D.C. – 503.644.8844***

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Description of the authority to sign.

Patient's Legal Name: _____ DOB: _____ - _____ - _____ ID #: _____

Welcome to Beaverton Family Chiropractic!

OFFICE CARE POLICIES

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read Our Office Policies, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Treatment,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interest to provide potential new patients as much information as possible about how the doctor at this office practices chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Beaverton Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Diversified, Instrument, Pettibon & Drop Table adjustments. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patient of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we encourage new patient's spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objects of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of "Our Office Care Policies". I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	____/____/____	_____
Patient's Name	Date of Birth	ID#:
_____	____/____/____	☐ *Witness Initials*
Patient's Signature	Today's Date	