Date _____ **CONFIDENTIAL CASE HISTORY** Case# _____

Name _____
(First) (Middle) (Last) (Nickname- Name you go by)

Home Address _____ Birthdate _____/ _____/ _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ email _____

Sex: M F Marital Status: S M D W Social Security Number _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Name of Spouse (or Responsible Party if Patient is a dependent Child) _____

Spouse's (Responsible Party's) Birth date _____/ _____/ _____ Social Security Number _____

Spouse's Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Referred by _____ Past Chiropractic Care ☐ Yes ☐ No When? _____

Doctor's Name _____ Results _____

Chief Complaint 1. _____

2. _____

3. _____

Insurance Companies _____

Are your present injuries due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other

Have you made a report of your accident? ☐ No ☐ Yes ☐ To employer ☐ Auto Carrier ☐ Other _____

Has the accident been reported? ☐ No ☐ Yes ☐ Workers Comp. ☐ Auto Carrier ☐ Other _____

Are you now or have you ever been disabled? (Service or Work)? ☐ No ☐ Yes When _____

Have you retained an attorney? ☐ No ☐ Yes Name & Address _____

PLEASE GIVE MOST CURRENT DATE

Spinal Exam _____

MRI Exam _____

X-ray Exam _____

Lab Exam _____

Last Physical _____

FEMALE ONLY

Papsmear _____

Breast exam _____

Implants _____

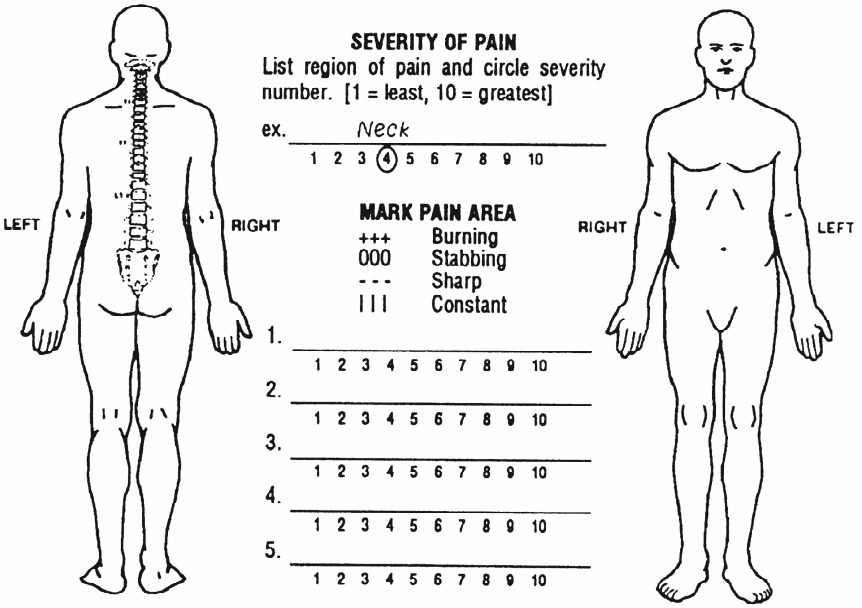
DOCTORS USE ONLY

_____

_____

_____

_____



Please mark area of pain on the drawing using the code listed above.

HABITS

☐ Smoking Packs/Day _____

☐ Drinking Alcohol _____

☐ Coffee Cups/Day _____

EXERCISE

☐ None

☐ Moderate

☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of ___	☐	☐	☐	☐	☐
Sister, No. of ___	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____541	Appendicitis	____285.9	Anemia	____429.9	Heart Disease	____716.9	Arthritis
____541	Pneumonia	____285.9	Measles	____429.9	Goiter	____716.9	Epilepsy
____541	Rheumatic Fever	____285.9	Mumps	____429.9	Influenza	____716.9	Mental Disorder
____541	Polio	____285.9	Chicken Pox	____429.9	Pleurisy	____716.9	Lumbago
____541	Tuberculosis	____285.9	Diabetes	____429.9	Alcoholism	____716.9	Eczema
____541	Whooping Cough	____285.9	Cancer	____429.9	Venereal Infection	____	AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if never. A complete history and understanding of you health will facilitate care.

GENERAL SYMPTOMS

____784.0 Headache
____780.6 Fever
____780.9 Chills
____780.8 Night Sweats
____780.2 Fainting
____780.4 Dizziness
____780.3 Convulsions
____780.52 Loss of Sleep
____780.7 Fatigue
____799.2 Nervousness
____783 Loss of Weight
____782 Numbness or pain in arms/legs/hands
____995.3 Allergy (What)
____786.09 Wheezing
____729.2 Neuralgia

GASTRO-INTESTINAL

____783 Poor Appetite
____536.8 Poor Digestion
____994.2 Excessive Hunger
____787.3 Belching or Gas
____787 Nausea
____787 Vomiting
____578 Vomiting Blood
____536.8 Pain over Stomach
____564 Constipation
____558.9 Diarrhea
____789 Colon Trouble
____455.6 Hemorrhoids (Piles)
____785.1 Liver Trouble
____782.4 Jaundice
____575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

____368.9 Poor Vision
____378.9 Crossed Eyes
____379.91 Pain in Eyes
____389.9 Deafness
____388.70 Earache
____388.30 Ear Noises
____388.60 Ear Discharges
____478.1 Nasal Obstruction
____784.7 Nose Bleeds
____462 Sore Throats
____784.49 Hoarseness
____477.9 Hay Fever
____493.9 Asthma
____460 Frequent Colds
____240.9 Enlarged Thyroid
____463 Tonsillitis
____686.9 Sinus Trouble

RESPIRATORY

____786.2 Chronic Cough
____786.3 Spitting Blood
____933.1 Spitting Phlegm
____786.50 Chest Pain
____786.09 Difficulty Breathing

GENITO-URINARY

____788.3 Frequent Urination
____788.1 Painful Urination
____599.7 Blood in Urine
____592 Kidney Infection
____788.3 Bed Wetting
____788.1 Inability to control Urine
____601.9 Prostate Trouble

MUSCLE & JOINTS

____ Weakness
____ Twitching
____847 Stiff Neck
____722.10 Backache
____719 Swollen Joints
____781 Tremors
____729.5 Foot Trouble
____724.79 Painful Tail Bone
____724.5 Pain Between Shoulders
____563.3 Hernia
____737.3 Spinal Curvature

CARDIO-VASCULAR

____783 Rapid Heart
____427.89 Slow Heart
____401.9 High Blood Pressure
____458.9 Low Blood Pressure
____786.51 Pain over Heart
____438 Previous Heart Trouble
____719.07 Swelling Ankles
____759.9 Poor Circulation
____ Varicose Veins
____436 Strokes

SKIN OR ALLERGIES

____368.9 Skin Eruptions
____698.9 Itching
____278.8 Bruising Easily
____701.1 Dryness
____ Boils
____782 Sensitive Skin
____708.9 Hives or Allergy
____692.9 Eczema
____ Medicines
_____
_____

FOR WOMEN ONLY

____786.2 Painful Periods
____626.2 Excessive Flow
____626.4 Irregular Cycle
____627.2 Hot Flashes
____625.3 Cramps or Backaches
____634.9 Miscarriage
____623.5 Vaginal Discharge
____ Pregnant at this Time
____ Last Pap
By Who _____
Other _____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other
	_____		_____		_____
	_____		_____		_____

List any accidents or falls and dates: ❒ Car _____ ❒ Recreational Vehicle _____ ❒ Sports _____
❒ School _____ ❒ Other _____

List any broken bones or dislocations (fractures): _____

Ever on crutches? ❒ No ❒ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ❒ Yes ❒ No

Were you ever knocked unconscious? ❒ Yes ❒ No

Have you ever had a lapse of memory? ❒ Yes ❒ No

Have you ever had x-rays taken? ❒ No ❒ Yes When? _____ By whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

Are you presently taking any medication - prescription or patent? ❒ No ❒ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

APC-CH-904.2

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Town and Country Chiropractic

Dr. Vanessa Pizza
255 N Main Street
Madison, GA 30650

Office (706)438-1314
Fax (706)438-1315
towncountrychirga@gmail.com

Patient's Name:_____#_____Date:_____

ACTIVITIES OF LIFE

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

	No Effect	Painful (can do)		Painful (limits)		Unable to perform
Carrying Groceries	☐	☐		☐		☐
Sit to Stand	☐	☐		☐		☐
Climbing Stairs	☐	☐	____steps	☐	____steps	☐
Pet Care	☐	☐		☐		☐
Driving	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Extended Computer Use	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Household Chores	☐	☐		☐		☐
Lifting Children	☐	☐		☐		☐
Reading/Concentration	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Bathing	☐	☐		☐		☐
Dressing	☐	☐	Upper/lower garments	☐	Upper/lower garments	☐
Shaving	☐	☐		☐		☐
Sexual Activities	☐	☐		☐		☐
Sleep	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Sitting	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Standing	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Yard Work	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Walking	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Sweeping/Vacuuming	☐ ☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Dishes	☐	☐	____minute(s)/hour(s)	☐	____minute(s)/hour(s)	☐
Laundry	☐	☐		☐		☐
Garbage	☐	☐		☐		☐
Other:_____	☐	☐		☐		☐

Patient's Signature:_____Date:_____

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PATIENT MEDICATION HISTORY FORM

PATIENT NAME:_____ DATE:_____

THE MEDICINES YOU TAKE ARE PART OF YOUR HEALTH INFORMATION. PLEASE FILL OUT THIS FORM TO BECOME PART OF YOUR RECORD.

CURRENT MEDICATIONS:

PRESCRIPTION DRUG NAME:	PRESCRIBED FOR:	SIDE EFFECTS (IF ANY)

OVER THE COUNTER MEDICATIONS (SUCH AS ASPIRIN, VITAMINS, HERBS)		

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To: _____

Fax: _____

From: _____

RECORDS RELEASE

RE: Patient's Name: _____

Patient's Date of Birth:: _____

To _____, I hereby authorize you to release to **Town and Country Chiropractic** any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

Date _____ Signature _____

Date _____ Witness Signature _____

_____ Please fax all medical records to: (706) 438 - 1315.

_____ Please mail all medical records to: 255 North Main Street Suite C. Madison, GA 30650

_____ Please mail a copy of the patients' X-RAY/ MRI / CT to 255 North Main Street Suite C. Madison, GA 30650

_____ Please email us a copy of medical records to: towncountrychiroga@gmail.com

_____ **Patient is Currently in our office.**

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OFFICE POLICY AUTHORIZATION FORM

Patient's Name _____

Patient SSN _____ Date of Birth _____

GENERAL INFORMATION

This information is requested by Town and Country Chiropractic for its own use/disclosure of protected health information. (Minimum necessary standards apply.) You have the right to inspect or copy the PHI to be used/disclosed. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Town and Country Chiropractic will not refuse to provide treatment. A copy of the signed authorization will be provided to you upon request.

SPECIFIC AUTHORIZATION

The patient identified above authorizes and grants permission for Town and Country Chiropractic to use and/or disclose protected health information (i.e. name, address)

- Birthday Cards
- Holiday-related Cards
- Newsletters
- Office Marketing Material
- Patient Referral Board
- New Patient Board
- Photo Board
- Thank You Gifts/Cards
- Appointment Reminders

I also give Town and Country Chiropractic permission to treat me in an "open room" environment whereas the door to the room will remain open. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will close the door to the room for these conversations.

By signing this form, you are giving Town and Country Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above unless indicated otherwise and to treat you in an open-room environment.

_____ _____

Signature of (patient/guardian if patient is a minor) Date

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization in whole or part, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

I have read or been provided with a Notice of *Patient Privacy Practices* that provides a description of healthcare information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Patient Signature: _____ Date: _____

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CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

AUTHORIZATION AND ASSIGNMENT

In Consideration of your undertaking to care for me, I agree to the following:

1. You are authorized 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 (the name(s) of which is believed to be correctly set forth under pertinent data) 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. However, it is understood 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 amount owed directly from me. I understand that whatever amounts you do not collect from the insurance company's proceeds, whether it is all or part of what is due, I personally owe you.
4. In addition to the above, the hereby waive the statute of limitations on collection and/or recovery in this state, **GA.**
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed, to **Town and Country Chiropractic**, are paid in full.

Signature _____ Date _____

Town and Country Chiropractic

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body the maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on the environment, underlying causes, and physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concerns as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic test, diagnosis, and analysis. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn thorough health care procedures whether he is suffering from latent pathological defects, illnesses, or deformities that would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond chiropractically may come under control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

I have read the foregoing and understand it.

_____ _____

Patient Signature Date

_____ _____

Witness Date