ASBURY FAMILY Chiropractic

2100 Asbury Road, Suite 6 Dubuque, IA 52001 (563)582-3424

Last_____First_____Birth Date_____

Address_____City_____ST_____Zip_____

Phone_____Cell phone carrier_____Email_____

Occupation_____Employer_____

Spouse's Name_____Spouse Ph_____

Children's Name & Ages_____

Have you had previous Chiropractic care? ☐yes ☐no

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

Who is your primary care physician?_____Phone:_____Date of last physical_____

May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

Please provide as much detail as possible.

Current Complaint:_____Date when symptom first appeared_____

How did it begin:_____

Have you ever experienced the same or similar symptoms? ☐yes ☐no When?_____

Have you been to another doctor for this problem? ☐yes ☐no

Who?_____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have numbness/tingling? ☐ yes ☐ no

Where?_____

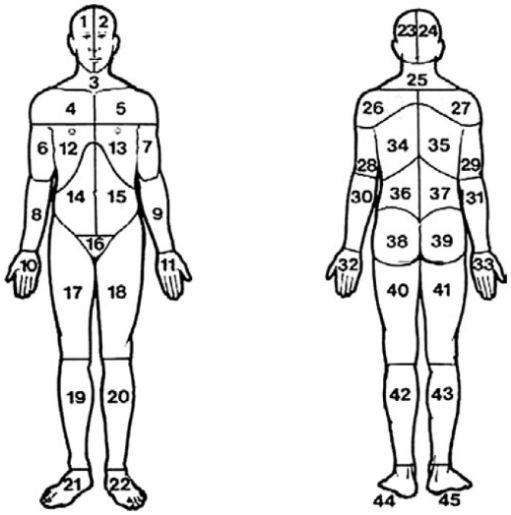
Does the Pain Radiate into: ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other _____ ☐ Does not radiate

What makes the symptoms increase?_____What relieves the symptoms?_____

Do any family members suffer from the same complaint? If so, who?_____

Please let us know your problem areas by using the numbers from the images to the right.

Numbers:



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

List all Medications/Vitamins:_____

Do you smoke? ☐yes ☐no How many packs per week?_____ If in the past, when did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week?_____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day?

Do you exercise? ☐yes ☐no If yes, how many mes per week and what type?_____

Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Health History- Please check all that apply

☐ AIDS/ HIV	☐ Allergy Shots	☐ Anemia	☐ Anorexia	☐ Appendicitis	☐ Arthritis
☐ Asthma	☐ Bleeding	☐ Breast Lump	☐ Bronchitis	☐ Bulimia	☐ Cancer
☐ Cataracts	☐ Chicken pox	☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout	☐ Heart dx
☐ Hepatitis	☐ Hernia	☐ Herniated disc	☐ Herpes	☐ High Cholesterol	☐ Kidney dx
☐ Liver dx	☐ Measles	☐ Migraines	☐ Miscarriage	☐ Mono	☐ M.S.
☐ Mumps	☐ Osteoporosis	☐ Parkinson's	☐ Polio	☐ Pacemaker	☐ Pacemaker
☐ Pneumonia	☐ Prostate	☐ Prosthesis	☐ Implants	☐ Rheumatoid	☐ Stroke
☐ Thyroid	☐ Tonsillis	☐ Tuberculosis	☐ Tumors	☐ Typhoid	☐ Fibromyalgia
☐ V.D.	☐ Whooping Cough	☐ Chronic Fatigue	☐ High BP	☐ Ulcers	

Other_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiroprac c adjustments and other chiroprac c procedures, including various modes of physical therapy and diagnos c X-rays, on me (or on the pa ent named below, for whom I am legally responsible) by the Doctor of Chiroprac c named below and/or other licensed doctors of chiroprac c who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiroprac c named below and/or with other office or clinic personnel the nature and purpose of chiroprac c adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the prac ce of medicine, in the prac ce of chiroprac c there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, disloca ons and sprains. I do not expect the doctor to be able to an cipate and explain all risks and complica ons, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctors feels at the me, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I also had an opportunity to ask ques ons about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the en re course of treatment for my resent condi on and for any future condi on(s) for which I seek treatment. **Initial**_____

Do you have health insurance:Yes ☐ No☐ Insuranceompany:_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I authorize payment of insurance benefits directly to Asbury Family Chiroprac c. I also authorize the doctor to release all informa on necessary to communicate with personal physicians, other healthcare providers, and/or payers to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient balances may not exceed $200 at any time. **Initial**_____

Patient's / Guardian's Signature_____Date:_____