Shell Chiropractic Inc.

Today's date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Age: ___ Marital Status: S M W D Spouses Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us: ○ newspaper ○ online ○ referral ○ Dr. referral

Referred by: _____ Number of children: _____

Have you had Chiropractic care before? _____ If yes, please list the doctors name _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type o exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier my pay less than the actual bill for service. I agree to be responsible for payment of all serves rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE

INFORMED CONSENT TO CHIROPRACTIC CARE

Shell Chiropractic, Inc.

114 W. Adams Ave, Suite C-105

Phoenix, AZ 85003

(602) 254-0177

Patient_____

Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment: Chiropractic Manipulative Treatment, Physical Therapy Modalities and Stretching/strengthening Exercises.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please print name of Signature of Patient, Parent, Guardian or Personal Rep. **Relationship to Patient**

Witness Signature_____ **Date** _____

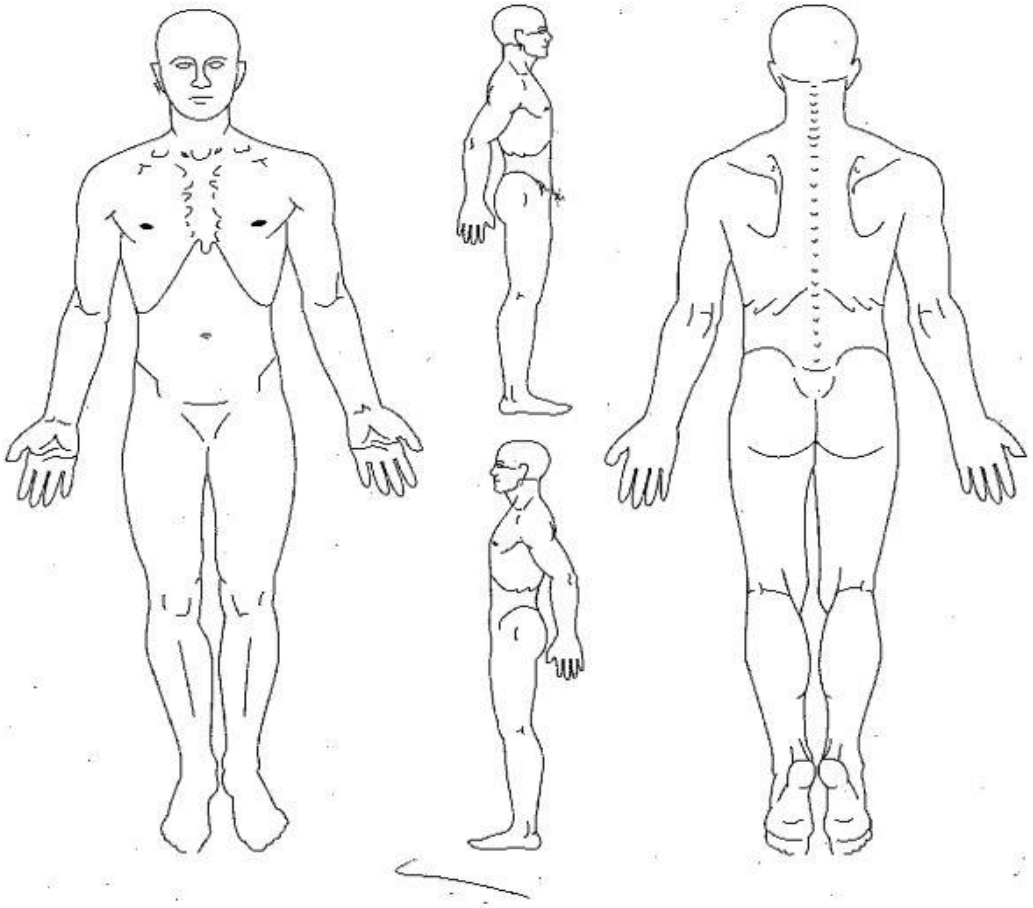
Doctor's Signature _____ **Date** _____

Patient Name: _____ Date: _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull **S** = Stabbing / Cutting **B** = burning

T = Tingling **N** = Numb **C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the Pain you have right **now**: Rate your pain at its **best** in the past week:

No Pain Unbearable Pain No Pain Unbearable Pain

|----------| |----------|

Rate your **average** pain in the last week: Rate your **worst** pain in the last week:

No Pain Unbearable Pain No Pain Unbearable Pain

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CANCELLATION POLICY

Shell Chiropractic
114 W Adams Ave Ste C-105
Phoenix, Az 85003
Barb Rogne D.C.
602.254.0177

Shell Chiropractic is happy to provide massage therapy as part of your treatment. We require that ***all patients*** *must call two (2) hours prior to your scheduled appointment time to cancel. If you do not, you will be billed $20.00, due on your next visit. The fee is to insure that our facility maintains quality therapists to assist us in meeting your health needs. Please keep in mind that our therapists do not get paid if you do not show up. Thank you for your cooperation.*

I have read and agree to the policy. I also understand that I may be billed $20.00 for any appointments that I do not call two (2) hours prior to cancel.

_____ _____

Signature of patient, parent, guardian or personal representative Date