**Confidential Patient Health Record** ***Today’s Date*:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

*How did you hear about us?* Family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Newspaper

 Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yellow pages Drove by Insurance Plan Facebook Radio

***Personal Information***

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suffix:\_\_\_\_\_\_\_

Birth Date: \_\_\_\_ /\_\_\_\_/\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Sex: Male / Female Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Race:African American Asian Caucasian Hispanic Multiracial Native American Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Widowed Divorced Separated

Eye Color: blue brown green grey hazel other: \_\_\_\_\_\_\_\_\_\_

Hair Color: black blonde brown gray red white other: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Work Phone:(\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verification Question (This is to help prevent Identity Theft)

What city were you born in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Employment Information***

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Emergency Contact***

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Spouse Relative Friend Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Cell Phone:(\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Work Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

##### Current Health Condition

**Unwanted Condition (Why you are here today?):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Use the letters BELOW to indicate the TYPE**

 **and LOCATION of your sensations right now.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT Key: A=Ache B=Burning N = Numbness

 **→→→→→→→ P=Pins & Needles S=Stabbing**

**When did this Condition BEGIN?** \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Has it ever occurred before? Yes No. When? \_\_\_\_\_\_\_\_\_\_\_\_**

**Is the Condition: Auto Related Job Related Home Injury**

 **Slip or Fall Lifting Slept Wrong Unknown Cause Other**

**Explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Accident:** \_\_\_\_\_\_\_\_\_ **Time of Accident**: \_\_\_\_\_\_\_\_ **am /pm**

**Condition/Pain STARTED on what Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you SUFFER with ANY OTHER Condition than which you**

**are now consulting us?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Previous Care for this Same Condition:***

 **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

**Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you satisfied with the results of your treatment? Yes No**

**Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Previous Chiropractic Care:* I have not previously seen a Chiropractor OR Fill in the information BELOW.**

 **Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_**

**Were you satisfied with your care? Yes No. Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you wear any of the following?Heel Lifts Innersoles Arch Supports Orthotics Other\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were they prescribed by a doctor? Yes or No.

**Do you currently smoke tobacco of any kind? \_\_Yes \_\_Never been a smoker \_\_Former smoker**

**If yes, How often do you smoke: \_\_Current Everyday smoker \_\_Current Someday smoker Packs per day \_\_\_\_\_\_\_ Years Smoked \_\_\_\_\_**

**If yes: What is your level of interest in quitting smoking?**

**List current medications including dosage, if known. If no medications are currently taken then check here:\_\_\_**

**1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any known allergies that you have to any medications. If no allergies are known then check here: \_\_\_**

**1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has any doctor diagnosed you with Hypertension presently? \_\_\_ Yes \_\_\_No If yes, what kind?**

**Has any doctor diagnosed you with Diabetes presently? \_\_\_ Yes \_\_\_No If yes, what kind? Type I or II?**

 **If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?Yes\_\_ No \_\_ Not Sure\_\_\_**

**Has any doctor diagnosed you with any type of significant health syndrome presently? Yes\_\_ No\_\_ Not Sure\_\_\_**

 **If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Illness (es):* LIST all health conditions. CIRCLE all CURRENT conditions.**

|  |  |  |  |
| --- | --- | --- | --- |
|  **ADD** |  **cystic kidney disease** |  **hypertension** |  **psychiatric problems** |
|  **alzheimers**  |  **depression** |  **influenzal pneumonia** |  **scoliosis** |
|  **anemia**  |  **diabetes (insulin dep)** |  **liver disease** |  **seizures** |
|  **arthritis**  |  **diabetes (non insulin)** |  **lung disease** |  **shingles** |
|  **asthma**  |  **eczema** |  **lupus erythema (discoid)** |  **past history of similar symptoms** |
|  **cancer**  |  **emphysema** |  **lupus erythema (systemic)** |  **STD’s (unspecified)** |
|  **cerebral palsy**  |  **eye problems** |  **multiple sclerosis** |  **suicide attempt(s)** |
|  **chicken pox**  |  **fibromyalgia** |  **parkinson’s disease**  |  **thyroid problems** |
|  **crohn’s/colitis**  |  **heart disease** |  **unspecified pleural effusion**  |  **vertigo** |
|  **CRPS (RSD)** |  **hepatitis**  |  **pneumonia**  |  **other:** |
|  **CVA (stroke)** |  **HIV** |  **psoriasis** |  |

***Surgery (ies):* LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

|  |  |  |  |
| --- | --- | --- | --- |
| **angioplasty** |  **cosmetic** |  **hysterectomy** |  **pacemaker insertion** |
|  **appendectomy** |  **D & C** |  **joint reconstruction** |  **rotator cuff** |
|  **caesarian section** |  **dental sugery** |  **joint replacement** |  **spinal fusion** |
|  **cardic catheterization** |  **gall bladder** |  **knee repair** |  **tonsilectomy** |
|  **carpal tunnel repair** |  **hemorrhoidectomy** |  **laminectomy** |  **other:** |
|  **coronary artery bypass**  |  **hernia repair**  |  **mastectomy** |  |

***Females ONLY: Ob/Gyn* Mark all that apply below.**

 **If you have been pregnant in the past, please fill in the appropriate information below.**

|  |  |
| --- | --- |
| **\_\_\_\_\_ Number of complicated pregnancies** | **\_\_\_\_\_ Number of uncomplicated pregnancies** |
| **\_\_\_\_\_Number of C-sections** | **\_\_\_\_\_ Number of vaginal deliveries** |
| **\_\_\_\_\_ Number of miscarriages** | **\_\_\_\_\_ Number of terminated pregnancies** |
| **I… am currently pregnant** |  **am NOT currently pregnant** |

**Menstrual History**

|  |  |
| --- | --- |
| **I… currently have menses.** |  **currently DO NOT have menses.** |
| **My menses… are regular.** |  **are NOT regular.** |
| **\_\_\_\_\_Age of first menses** | **\_\_\_\_\_ Age when metaphase began** |
| **Date of last menses: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** |  |

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand

that the Chiropractic Clinic 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 Chiropractic Clinic will be credited to my account upon 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

**I hereby authorize the Doctor to treat my condition as he or she 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 negative 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.**

**I hereby authorize the providers of LinnChiropracticCenter to administer such procedures as may be deemed necessary in the diagnosis and treatment of the patient.I hereby authorize release of any medical information regarding this visit to my insurance and or primary care physician, and also ASSIGN to the Provider all payments from Medicare, Midlands Choice, Blue Cross/Blue Shield, Medicaid, and my insurance if not listed.I Understand that I am financially responsible for all charges whether or not paid by my insurance.**

**I Understand that not all providers at LinnChiropracticCenter may be a participating provider with my insurance.  I Understand that I am responsible for the charges not covered by my insurance. A late fee of $17.50 will be added to all accounts unpaid for 90 days.  I will also be liable for all legal and collection fees.I understand and Agree to the above conditions.**

I acknowledge that I have received the Chiropractic Clinic’s Notice of Privacy Practices for protected health information.

### Patient Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Consent to treat a Minor Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to treat a Minor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

****Payment for services is due on the day of service.  As part of our service, we will submit your claim to your insurance.****

**VERIFICATION OF NOT PREGNANT (for females only)**

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LINN CHIROPRACTIC CENTER, P.C.

INFORMED CONSENT IN THE STATE OF NEBRASKA

FROM THE PATIENT

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 such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

INTRODUCTION

The professions of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and others are regulated in the State of Nebraska. Patient care and treatment provided by those above listed professions have known risks, which may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such care and treatment.

Chiropractic is a science which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) of the body as the relationship may effect the restoration and preservation of health. For your information, the following is routinely furnished to all who consider chiropractic care and treatment in this clinic.

NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors to connect spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or initiation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). This is done with a chiropractic adjustment following a chiropractic examination which may include, but is not limited to spinal and physical examination, orthopedic and neurologic testing, palpation, specialized instrumentation, radiology examinations, and laboratory tests. 

An adjustment is the application of a quick precise movement over a very short distance to the spine or extremity. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. In addition, physiotherapy and/or rehabilitative procedures may be included in the management protocol.

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps, death through complicating factors. Risks associated with physiotherapy may include not only the foregoing but also allergic reaction, muscle and/or joint pain.

AUTHORIZATION FOR CHIROPRACTIC CARE AND TREATMENT

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE LINN CHIROPRACTIC CENTER, P.C. TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

ON THIS DATE: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| PATIENT'S SIGNATURE |  DOCTOR OF CHIROPRACTIC'S |
|  |  SIGNATURE |

WHEN THE PATIENT IS A MINOR OR UNABLE TO CONSENT:

A. PATIENT IS A MINORYEARS OF AGE

B. OTHER

PATIENT'S NAME:

PERSON AUTHORIZED TO SIGN FOR PATIENT, PLEASE PRINT NAME:

SIGNATURE OF AUTHORIZED PERSON:

RELATIONSHIP:



SIGNATURE OF DOCTOR OF CHIROPRACTIC:

REMARKS: