PATIENT INFORMATION

DATE: _____ ACCOUNT# _____

First Name _____ Initial _____ Last _____ Called _____

Address _____ City _____ State _____ Zip _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email: _____

DOB _____ Social Security# _____ Marital Status: M S D W O Sex _____

Work Status (circle one) Employed Unemployed Retired Full-Time Student Part-Time Student

Occupation _____ Employer _____

Who may we thank you for referring you to us? _____

EMERGENCY CONTACT: Name/Relationship: _____

Home # ( ) _____ Cell ( ) _____

Reason(s) for todays visit: _____

_____

Type of Accident/Injury Auto Sports Work Related Other

Date of Accident/Injury _____

PLEASE INDICATE YOUR FUTURE APPOINTMENT REMINDER PREFERENCE

Phone Call to: Home _____ Work _____ Cell _____

HEALTH HISTORY

Do you smoke? No _____ Yes _____ How many? _____ How Long? _____

For Women: Are you pregnant? No _____ Yes/How long? _____ Nursing: Yes No

Are you taking any medications? No _____ Yes _____

Please list all medication(s) including dosage(s) you are currently taking:

Please place a check mark if you have or had any of the following:

_____ Severe/Frequent Headaches	_____ Anemia	_____ Congenital Heart Defect
_____ Sinus Problems	_____ Artificial Bones/Joints	_____ Heart Surg/Pacemaker
_____ Shingles	_____ Neck Pain	_____ Heart Murmur
_____ Diabetes/Tuberculosis	_____ Lower Back Pain	_____ Mitral Valve Prolapse
_____ Kidney Problems	_____ Heart Attack	_____ Artificial Valves

FAMILY HISTORY

Please list anything you may be allergic to: _____

Please list previous Injuries, Surgeries/Treatments with dates: _____

Healthy Lifestyles Wellness Center

Dr. Kris Kirby, DC *Dr. Cammie Svuba, DC* *Dr. Chase Johnson, DC*

CONSENT TO TREATMENT FORM

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

***** I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

***** I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responisbility to inform this office of any changes in medical status

***** I hereby request and consent to treatment, procedures, and/or tests performed by Healthy Lifestyles Wellness Center, LLC and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of any procedure which the doctor feels at the time is in my best interest.

***** I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signature _____ Date _____

For Minor Child: I authorize the licensed doctor and whoever he/she may designate as assistants to administer chiropractic care as deemed necessary to: _____

(Name) _____ (Relationship) _____