Bautista Chiropractic Care

Name _____ Date _____

Address _____ City _____ State _____ Zip code_____

Phone # _____Social Security # _____ Driver Lic. #_____

Age_____ D.O.B._____ Sex: M / F Status: M / S / D / W No. of children_____

Occupation_____ Employer _____Years Employed _____

Work phone # _____Ext._____ Referred by _____

Do you have Health Insurance? Yes / No

Do you have Chiropractic benefits? Yes / No

Insurance Company name_____ Ins. ID #_____

Subscriber's name_____ DOB_____

Subscriber's employer_____

Relationship to Subscriber: Self / Spouse / Dependent / Other_____

Date problem began: _____ has the pain gotten: Better / Worse / No Change

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? Constant / Frequent / Occasional

Please describe your problem and how it began: _____

_____

Describe your pain/symptoms: (Circle what pertains to you)	Sharp	Stabbing	Throbbing	Aches
	Dull	Numbness	Soreness	Shooting
	Burning	Tingling	Weakness	Gripping
What makes the pain better? :	Standing	Lying down	Walking	Exercise
	Sitting	Movement	Stretching	Nothing
What makes the pain worse? :	Standing	Lying down	Walking	Exercise
	Sitting	Movement	Stretching	Nothing

What treatment have you had for this condition in the past? (Surgery, medications, injections, therapy, chiropractic) _____

Have you had X-rays, MRIs or other tests for this condition? What tests and When? _____

_____

Patient Signature_____ Date: _____

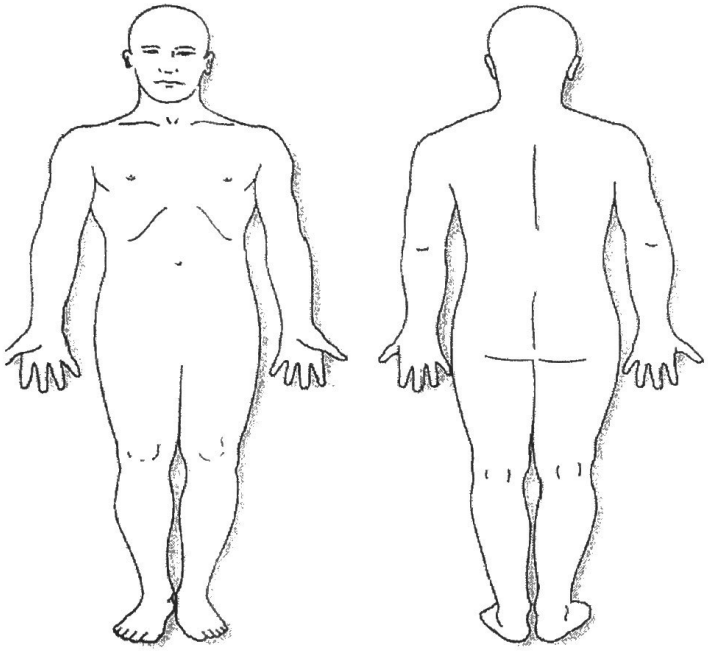
Health History

Do you have any of the following: (Circle the symptoms that pertain to you current or past)

Abdominal pain	Digestive problems	Asthma	Cancer
Rash	Dermatitis	Infection	Blood Disorder
High Blood Pressure	Emphysema	Arthritis	Ulcer
Chest Pain / Conditions	Diabetes	HIV/Aids	Lung Problems
Heart Problems	Headaches	Jaw Pain	Sinus/Allergies
Stroke	Aneurysm	Other_____	

Describe your job requirements: Mainly sitting Light labor Heavy labor

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS, OR TINGLING.



Please read before signing:

I clearly understand and agree that I am responsible for payment of any and all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during the treatment.

I, the undersigned, affirm that the above is true and correct, and consent to chiropractic care in this office.

Patients Signature: _____ Date: _____

Informed Consent Acknowledgement

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me, or patient named above, for whom I am legally responsible, by Dr. Marvin I. Bautista, D.C. and/or other licensed doctors of chiropractic 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 chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand 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, stroke, burns, dislocations, or sprains/strains. These complications/risks are considered rare. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____

Print Name

_____

Parent or Guardian Signature