

Welcome to Quantum Chiropractic Arts. Please help us with your case file by filling out this patient admittance form as completely as possible. This is **confidential** information and will not be released to anyone without your written permission. Thank you.

Name	Ad	ldress					
City	State	_ Zip	Telephone				
Birth Date Age_	Marital S	Status					
Occupation	Employer_		Work Phone				
Spouse	Spo	Spouse's Employer					
Please describe the health concerns t	for which you ha	ve come to	o our office:				
Do you believe this condition is gett Do the symptoms seem to: Come a	ry ing progressively nd go? B Be Worse at nigh	Have you Better?_ constant; t? I	w missed any days of work? Worse? About the same? Be worse in the morning? Interfere with work? Interfere with				
Do you have other physical complaints seemingly not related to the above? If so, please describe:							
Please list all surgeries and approxing							
Please list any medications you are now taking. (Include over-the-counter drugs.)							
Please list any vitamins, nutritional supplements or homeopathic remedies you are now using.							
Vho referred you to our clinic? Today's date:							

Payment is required when services are rendered, unless other arrangements have been made in advance. Please pay before leaving. Thank you.

Below is a list of conditions which may seem unrelated to the condition which brought you into our clinic. However, we would like you to consider them carefully, as some of these problems can affect your overall health, diagnosis and treatment plan. Thank you.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD AND GIVE THE APPROXIMATE DATE, IF POSSIBLE

II FOSSIBLE.				
Appendici Scarlet Fey Dipththeria Typoid Fe Pneumonia Rheumatic Polio	Zer Tube a Who ver Aner a Meas	rculosis oping Cough nia sles ips	Chicken Pox Diabetes Cancer Heart Disease Goiter Influenza Pleuresy	Venereal Infection Arthritis
PLEASE CHE	CK ANY OF THE FOLLOW	ING YOU HAVE NO	W (N) OR HAVE	HAD IN THE PAST (P).
	Paralysis Dizziness Forgetfulness Confusion/depression Fainting Convulsions Cold/tingling extremeties Allergies Loss of Sleep Fever Headaches Poor or excessive appetite			Abdominal cramping Gas/bloating after meals Heartburn Black/bloody stool Colitis Bladder trouble Painful/excessive urination Discolored urine Chest pain Shortness of breath Blood pressure low/high Irregular heartbeat Heart "problems" Lung problems/congestion Varicose veins Ankle swelling Vision problems Dental problems Sore throat Earache Hearing difficulty Stuffed nose Menstrual irregularity/cramping Vaginal pain/infections Breast pain/lumps Prostate/sexual dysfunction Genital herpes
Long Labor? _ Other? WOMEN ONI Pregnant now? Any problems Any problems Abortions/miso	edge, did your birth involve: Inducement? Ca Don't know Age menstruation sta during pregnancy or delivery during menopause? earriages? Approx. date: s? Bladder infection	rted?		ease outline on the diagram he area of your discomfort



PATIENT INFORMATION AND CONSENT FORM

You have requested a chiropractic evaluation, which in this office utilizes Applied Kinesiology for diagnosis as an additional support and in conjunction with other standard chiropractic testing procedures.

The practice of Applied Kinesiology was originally developed by Dr. George Goodheart of Detroit, Michigan in 1964 and is used today by many doctors of medicine, osteopathy, dentistry, and psychology, as well as chiropractic, for diagnosis and therapy.

Applied Kinesiology uses muscle testing as a supplemental procedure for diagnosis, treatment and/or nutritional recommendations. This procedure is considered experimental in nature and, while there has been some peer review research and publications of Applied Kinesiology in professional journals, some of the techniques have not been supported by a body of evidence using standard scientific research methodologies.

The Doctor of Chiropractic in this office has received education and training in the use of Applied Kinesiology diagnosis and specialized therapy.

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

I have read the above and understand that Applied Kinesiology is considered "experimental" in nature. I take responsibility for diagnosis and treatment procedures agreed upon by the Doctor of Chiropractic and myself. I reserve the right to accept or reject any recommendations related to Applied Kinesiology.

I understand and agree that any health and/or accident insurance policies are an arrangement between the insurance carrier and myself. The doctor's office will prepare any necessary forms to assist me in making collection (reimbursement) from the insurance company; however, I am responsible for payment.

I have completed the information to the best of my knowledge and will inform this office of any changes in my medical status, address or phone numbers.

status, address or phone numbers.

I authorize the release of any medical information necessary to process an insurance claim.

I authorize payment of benefits to the undersigned physician for services rendered to me.

DATE: ______ PATIENT'S SIGNATURE ______

DOCTOR'S SIGNATURE ______

OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF THE OFFICE VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER. THANK YOU!!