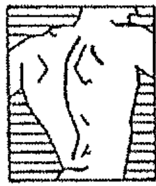


Bentley Chiropractic

1549 Ebenezer Rd
Rock Hill, SC 29732

Wellness Center
www.bentleychirowellness.com

Ph: (803) 980-7190
Fax: (803) 980-7191

SECTION I **PATIENT INFORMATION** **DATE**_______________

Name:____________________________________ **I prefer to be called:** ____________________

"X" Appropriate Boxes: ☐Male ☐Female ☐ Minor

"X" Appropriate Boxes: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

"X" Appropriate Boxes: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White

Address:___________________________**#**________**City:**______________**State:**______**Zip**________

Phone (______)______________ **Work Phone** (_____) ______________ **Cell Phone** (_______)__________________

The best time to contact me is:________________ ☐A.M. ☐P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____________ **Age**________ **Social Security Number:**________-______-___________

If Student, Name of School__________________________ **City/State**__________________________ ☐ FT ☐ PT

Spouse or Parent's Name:__________________________**Employer**_________________ **Work Phone**_______________

Whom may we thank for referring you? ____

If you were not referred, how did you hear about us?____

Person to contact in case of emergency_________________________________ **Phone**__________________________

Name of local primary physician______________________________________**May we contact them?**_______________

Email Address____**May we contact you via email?** ☐ Yes ☐ No
MOBILE PROVIDER___________________ **We will use this information to send you automatic text appointment reminders.**
****We will not sell or distribute your email address to any 3rd parties. Email address is used for newsletter and patient communication regarding special events and announcements.**

TELL US ABOUT YOUR PAST HEALTH:

Y	N	⟵ Lower Back Pain	Y	N	⟵ Diabetes (A1C=_______)	Y	N	⟵ High Cholesterol
Y	N	⟵ Leg/Foot Pain/Numbness	Y	N	⟵ Hand Problems	Y	N	⟵ Shingles
Y	N	⟵ Prior Spinal Surgeries	Y	N	⟵ Neuropathy	Y	N	⟵ Knee Surgery
Y	N	⟵ Spinal Fractures	Y	N	⟵ Heart Attack	Y	N	⟵ Kidney Issues/Dialysis
Y	N	⟵ Spinal Stenosis	Y	N	⟵ Heart Problems	Y	N	⟵ Gout
Y	N	⟵ Spinal Arthritis	Y	N	⟵ High/Low Blood Pressure	Y	N	⟵ Hip Surgery
Y	N	⟵ Sciatica	Y	N	⟵ Vascular Leg Problems	Y	N	⟵ Leg Fractures
Y	N	⟵ Neck Pain	Y	N	⟵ Vascular Surgery _______	Y	N	⟵ Joint Replacement
Y	N	⟵ Herniated Disc	Y	N	⟵ Stroke	Y	N	⟵ Foot Surgery

SECTION III **CURRENT/CHIEF COMPLAINT(S)**

Main Complaint______________________________ **Location:** ☐Left ☐Right ☐Middle

How long? ☐___Days ☐___Weeks ☐___Months ☐___Years

How often? ☐Constant ☐Frequent ☐Intermittent ☐Occasional

What do you think may have caused this problem? ______________________________

If auto accident – Date of Accident______________

SECTION III continued

Does the pain radiate? ☐Yes ☐No **If yes, where?** ______________________________

Associated Symptoms? ☐Inflexibility ☐Stiffness ☐Spasms ☐Cramps ☐Other______________

DESCRIBE THE PAIN/SYMPTOMS ("X" ALL THAT APPLY)?

☐Dull	☐Sharp	☐Numb	☐Weak	☐Prickly
☐Aching	☐Crawling	☐Itching	☐Tingling	☐Shooting
☐Stinging	☐Stabbing	☐Hurting	☐Burning	☐Throbbing
☐Pounding	☐Pulsating	☐Deadness	☐Excruciating	☐Pins & Needles

☐Other______________________________

WHAT AGGRAVATES THE PAIN/SYMPTOMS?

☐Flashing lights	☐Coughing	☐Sneezing	☐Standing	☐Sitting
☐Getting up	☐Carrying	☐Pushing	☐Pulling	☐Depression
☐Straining at BM	☐Lifting	☐Stooping	☐Stress	☐Emotional upset
☐Climbing stairs	☐Exercising	☐Looking side/side	☐Driving	☐Walking
☐Walking uphill/downhill	☐Looking up/down	☐Repetitive movement	☐Getting in/out of car	☐Anger

☐Other______________________________

WHAT RELIEVES THE PAIN/SYMPTOMS?

☐Resting	☐Shower	☐Sleeping	☐Sitting	☐Standing
☐Lifting	☐Stooping	☐Exercising	☐Turning head	☐Looking up/down
☐Tylenol	☐Advil	☐Aspirin	☐Icy Hot	☐Lying Down
☐Fetal position	☐Bending forward	☐Leaning backward		

☐Other______________________________

HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? ☐Yes ☐No

IF YES, WHOM? ______________________ **WHEN?**______________________

How would you describe your average pain over the past week?

No Pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

SECTION IV **HEALTH HISTORY**

Please "X" All That Apply – Past or Present

☐AIDS/HIV	☐Allergy Shots	☐Anemia	☐Anorexia	☐Appendicitis	☐Arthritis	☐Asthma
☐Bleeding	☐Breast Lump	☐Bronchitis	☐Bulimia	☐Cancer	☐Cataracts	☐Chicken Pox
☐Depression	☐Diabetes	☐Emphysema	☐Epilepsy	☐Fibromyalgia	☐Fractures	☐Glaucoma
☐Goiter	☐Gonorrhea	☐Gout	☐Heart Disease	☐Hepatitis	☐Hernia	☐Herniated Disc
☐Herpes	☐High Cholesterol	☐Kidney Disease	☐Liver Disease	☐Measles	☐Migraines	☐Miscarriage
☐Mono	☐M.S.	☐Mumps	☐Osteoporosis	☐Pacemaker	☐Parkinson's	☐Pneumonia
☐Polio	☐Prostate	☐Prosthesis	☐Implants	☐Rheumatoid	☐Stroke	☐Thyroid
☐Tonsillitis	☐Tuberculosis	☐Tumors	☐Typhoid	☐Ulcers	☐V.D.	
☐Chronic Fatigue	☐Whooping Cough	☐High Blood Pressure		☐Other________		

PREVIOUS SURGERIES & DATES: ______________________________

____

Please List Any Medications You Are Taking: ______________________________

____

____

____

PLEASE LIST ANY ALLERGIES: ______________________________

____

____

LIST ALL SUPPLEMENTS YOU ARE CURRENTLY TAKING: ______________________________

______________________________.

DO YOU DRINK ALCOHOL? ☐Yes ☐No **HOW OFTEN?** ____________ **PER WEEK**

DO YOU SMOKE? ☐Yes ☐No **HOW OFTEN?** ____________ **PER WEEK**

DO YOU USE RECREATIONAL DRUGS? ☐Yes ☐No **HOW OFTEN?** ____________ **PER WEEK**

DO YOU HAVE A PACEMAKER? ☐Yes ☐No **HAVE YOU HAD PRIOR SPINAL SURGERY?** ☐Yes ☐No

WOMEN

DO YOU THINK YOU MIGHT BE PREGNANT? ☐Yes ☐No **ARE YOU PREGNANT?** ☐Yes ☐No

DATE OF LAST CYCLE: ____________ NURSING? ☐Yes ☐No **BIRTH CONTROL?** ☐Yes ☐No

PATIENT HISTORY WAS OBTAINED FROM: ☐Patient ☐Father ☐Mother ☐Son ☐Daughter ☐Other__________

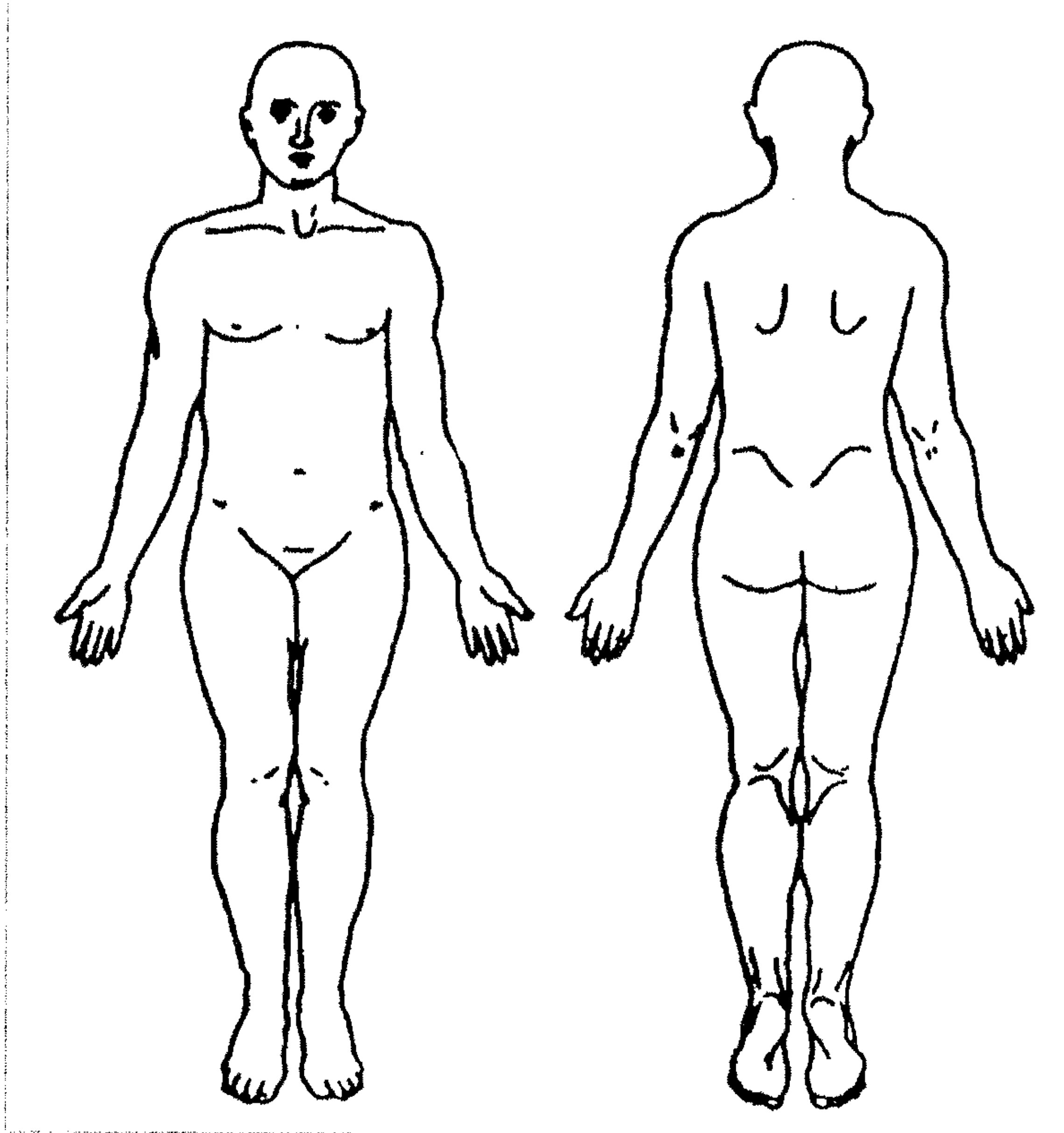
Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:

Use the Following Symbols:

Pain = X

Numbness/Tingling = O

Stiffness = ☆



Walking Scale Questionnaire

For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

In the past 2 weeks how much has your knee pain...	Not at All	A Little	Moderately	Quite a Bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up/down stairs?	1	2	3	4	5
Made standing when doing things more difficult?	1	2	3	4	5
Limited your balance when standing/walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors? E.G. – Holding onto furniture, using a cane, etc.	1	2	3	4	5
Made it necessary for you to use support when walking outdoors? E.G. – Holding onto furniture, using a cane, etc.	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

WALKING SCALE DISABILITY SCORE: <NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

Subjective Peripheral Neuropathy Screen Questionnaire

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Circle **YES** or **NO** based on how you usually feel.

1.	Do you ever have legs and/or feet that feel numb?	YES	NO
2.	Do you ever have any burning pain in your legs and/or feet?	YES	NO
3.	Are your feet too sensitive to touch?	YES	NO
4.	Do you get muscle cramps in your legs and/or feet?	YES	NO
5.	Do you ever have any prickling or tingling feelings in your legs or feet?	YES	NO
6.	Does it hurt at night or when the covers touch your skin?	YES	NO
7.	When you get into the tub or shower, are you unable to tell the hot water from the cold water with your feet?	YES	NO
8.	Do you ever have any sharp, stabbing, shooting pain in your feet or legs?	YES	NO
9.	Have you experienced an asleep feeling or loss of sensation in your legs or feet?	YES	NO
10.	Do you feel weak when you walk?	YES	NO
11.	Are your symptoms worse at night?	YES	NO
12.	Do your legs and/or feet hurt when you walk?	YES	NO
13.	Are you unable to sense your feet when you walk?	YES	NO
14.	Is the skin on your feet so dry that it cracks open?	YES	NO
15.	Have you ever had electric shock-like pain in your feet or legs?	YES	NO

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name ______________________________ Date ______________

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

____

____

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
A I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

____
Examiner

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name ____________________ Date ____________________

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just ***mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (washing, dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-3 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

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____
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: *A study of reliability and validity.* J Manipulative Physiol Ther 1991;14:409-415, Copyright Vernon H and Hagino C, 1990.

Bentley Chiropractic
Wellness Center

Dr. Mark Bentley

Informed Consent and Authorization for Medical Treatment

I understand that medical practice is an inexact science and that the risk of injury is present whenever diagnosis and treatment are undergone. I acknowledge that no guarantees have been made to me as a result of my participation in examination and treatment by the above named physician.

I have been informed of the nature and risk involved in the proposed treatment, possible alternative methods of treatment, and possible consequences or complications arising from treatment. I have had ample opportunity to ask questions of the doctor in order to find out as much as I can about the proposed treatment(s) and my other options. Equipped with this knowledge, I freely consent to care and treatment, and by signing this form attest that I do so under no coercion.

I have read and understood the above paragraphs and am aware that no claims or therapeutic guarantees have been made.

I understand that information revealed in my record may be used for research purposes, and that I will never be personally identified in the course of such use of my medical record.

I agree to permit Dr. Bentley to discuss my case with medical colleagues and allied health professionals in his efforts to obtain other professional opinions about treatment course and treatment options.

Patient Name (Print): ____

Patient Signature: ____

HIPAA DECLARATION

This Notice is in effect as of 10/27/2014

The Practice:
(a) Is required by federal law to maintain the privacy of your Protected Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Protected Health Information.
(b) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of you Protected Health Information than that which is provided for under federal law.
(c) Is required to abide by the terms of the Privacy Notice.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Protected Health Information that it maintains.
(e) Will distribute any revised Privacy Notice to you prior to implementation.
(f) Will not retaliate against you for filing a complaint.

PATIENT ACKNOWLEDGMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

__________________________________ __________________________

Signature of Patient/Guardian Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Patient's acknowledgment of this Notice could not be obtained because:

☐ Patient refused to sign ☐ Communication barrier prohibited obtaining acknowledgment
☐ Emergency circumstances ☐ Other

Signature of Practice ____________________ Date ____________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to BENTLEY CHIROPRACTIC WELLNESS CENTER, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30/45 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

Signature of Insured/Guardian ____________________ Date ____________________

SECTION VII — CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I,_________________________________, being the parent or legal guardian of _________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_______________________________ _______________

Signature Date

SECTION VIII — FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to any attorney/outside agency for collection and/or suit, BENTLEY CHIROPRACTIC WELLNESS CENTER shall be entitled to reasonable attorney's fees and for cost of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_______________________________ _______________________________ _______________

Patient Signature Insured's Signature Date

SECTION IX — TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustment of the spine and/or extremities.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express itself to its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnoses or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral and/or extremity subluxations. Other methods of treatment such as physical therapy modalities, rehabilitation, and/or manual therapy techniques may be employed as well to assist in the prevention of exacerbations of the condition as the nerve interference is being removed by specific adjustments of the spine and/or extremities.

I, _________________________________, have read and fully understand the above statements.
(print name)
I, therefore, accept chiropractic care on this basis.

_______________________________ _______________

Signature Date