elev8 chiropractic

your next level awaits!

Today's Date _____/_____/_____

Name _____

Birth Date _____/_____/_____ Age_____ SSN_____

Address _____

City, State, ZIP _____

Home Phone ☐_____ Cell Phone ☐_____
(Check the best number to contact you)

Email Address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Occupation _____ Employer _____

Number of Children _____

How can we help you today?

Your Health & Well-Being

Do you take supplements or vitamins? ☐Yes ☐No Please list: _____

Please rate the following using P=Poor, G=Good, or E=Excellent: Diet: P G E Exercise: P G E Sleep: P G E

Please describe your stress level (1=low, 10=high): Occupational: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

Do/Did you smoke? ☐Yes ☐No Packs/Day_____ When did you quit?_____

Do you consume alcohol? ☐Yes ☐No How many drinks per week?_____

How many caffeinated beverages do you consume daily? _____ How many carbonated beverages?_____

For women: Are you taking birth control? ☐Yes ☐No Are you pregnant? ☐Yes, Weeks_____ ☐No

ACKNOWLEDGEMENTS

To set clear expectations and improve communications, please read each statement and sign below.

I acknowledge any insurance I may have is a contract between the carrier and myself and I am responsible for the payment of any covered or non-covered services I receive.

I authorize the doctor and staff to perform any necessary services needed during diagnosis and treatment.

I have read and reviewed this office's Privacy Policy, and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. Treatment in our office is performed in a joint treatment space which is in full compliance with all applicable privacy laws and regulations.

I have read and reviewed the Informed Consent to Treat on the back of this form and had an opportunity to ask any questions about its content. By signing this form, I intend this consent to cover the entire course of treatment for my current condition and any future condition(s) for which I seek treatment.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Signature_____ Date_____

Informed Consent to Treat

I hereby request and consent to the performance of procedures, including examinations, chiropractic adjustments and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Elev8 Chiropractic team. This also includes other licensed providers and support staff who now or in the future treat me while employed by, associated with, or serving as back-up providers for Elev8 Chiropractic.

I have had an opportunity to discuss with the Elev8 Chiropractic provider and/or staff the nature and purpose of the procedures.

I understand and I am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment. These include, but is not limited to: muscle spasms for short periods of time, aggravation and/or temporary increase in symptoms, lack of improvement in symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Elev8 Chiropractic provider to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise his/her judgment during the course of the procedure which the doctor feels at the time is in my best interest, based upon the facts then known.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition. These treatment options include, but is not limited to: over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers, physical therapy, steroid injections, bracing and surgery.

I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns about the nature of my symptoms and treatment options.