MODERN
CHIROPRACTIC
C E N T E R

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9841 Pines Boulevard
Pembroke Pines, FL 33024

New Patient Consultation Form

Today's Date ___/___/____

Patient's Name____

Mailing Address__________________________ City __________ State ____ Zip __________

Birth Date ____/____/____ Age _________

Cell Phone Number (____) ____-_______ Home Phone Number (____) ____-_______

*Insured Name & ID*____ *DOB: ____/____/ _______*
(If different from patient)

Email Address: ____

Referred By ____

Occupation ____

Hobbies ____

Please describe the pain and its location _____________________________________

____

Explain what happened ____

____

When did the condition begin?____

Did the condition arise from auto accident, sports, work, trauma o other related reasons?

____

____

Is the condition getting worse or better? _____________________________________

Did you go to the Hospital for this condition?__________ if yes, explain the treatment or diagnostic testing you received ____

____

Did you go to a physician or other Chiropractor for this condition? ________ if yes, please explain the outcome of the treatment or visit _____________________________________

____

Have you had this condition in the past? __________ if yes, please explain ______________

____

What activities aggravate the condition? ____

What activities relieve the condition?____

Did you use Ice or Heat to try to relieve this condition?______________________________

What medication have you taken for this condition? ________________________________

What medication or supplements are you presently on?_____________________________

Please circle if you have had any of these conditions or diseases:

Heart attack	Stroke	Congenital Heart Disease	Alcoholism
Diabetes	Cancer	High/Low Blood Pressure	Drug Abuse
HIV	Headaches	Lower Back Pain	Shoulder Pain
Lung Problems	Neck Pain	Difficulty Breathing	Dizziness
Hepatitis	Epilepsy	Stomach Problems	Asthma
Arthritis	Concussions	Knee Problems	

Other Conditions ____

____

Do you smoke tobacco? ______

Women: Are you Pregnant? __________ If yes, how many weeks? __________

In case of an emergency, who should we contact? __________________________________

Emergency contact's relationship_____________ and phone number___________________

Financial Policy:

Our Policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the Doctor. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for Small claims court fee, collection agency fees, legal fees, the doctor's hourly rate for court appearance, and any other expenses that are incurred in collecting on your account. Patient is responsible for the knowledge of their own insurance benefits, and is ultimately responsible for any treatments not covered by your insurance.

I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider and or manage care organizations, 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 responsibility to inform this office of any changes to the information I have provided.

Chiropractic Informed Consent to Treat:

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 on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories of this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand an 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 futures condition(s) for which I seek treatment.

Print Name ______________________________________ Date _____________________

Signature ____