# Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C. | John Chapman, D.C.

Today's Date: ______________ **PATIENT INFORMATION** Date of Injury (DOI): ______________

**PATIENT:** Last Name:______________ First Name: ______________ Mid Initial: ________

DOB (Month/Day/Year):____/____/________ Age:______ Gender: M // F SS#:______________

Address:______________ City:______________ Zip Code: ______________

Cell #:______________ Home #:______________ Work #: ______________

Email Address: ______________

**VITALS:** Height:__________ Weight:__________ Dominant Hand: Right // Left

**PRIMARY DOCTOR:**______________ City:__________ Phone #: ______________

**EMPLOYER NAME:**______________ Occupation:______________

Address:______________ City:______________ Zip Code: ______________

Phone #:______________ Fax:______________ # Hours/Week Worked: ______________

**EMERGENCY CONTACT:**______________ Relation:__________ Phone #: ______________

**HEALTH INSURANCE INFORMATION:** Policy #:______________ Group #: ______________

Policy Holder Name:______________ Phone #: ______________

**ATTORNEY NAME:** ______________

Phone #:______________ Fax #:______________ Case Mgr: ______________

Firm Address: ______________

## SHOW ME WHERE IT HURTS

*Please mark your pain level from 0-10.*

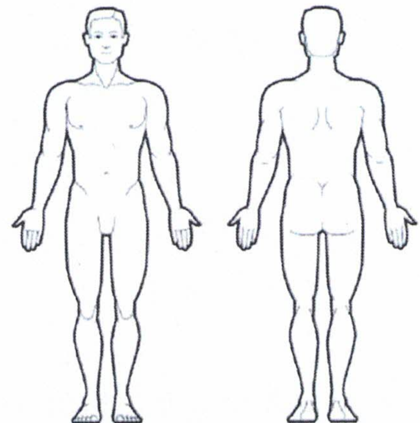
| No pain | Minimal | | | Slight | | Moderate | | | Severe Pain | |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

- ❑ Constant
- ❑ Frequent
- ❑ Intermittent
- ❑ Occasional

Description of Pain: (circle all that apply.)

| | | | |
|---|---|---|---|
| (DL) | Dull | (SO) | Sore |
| (A) | Achy | (T) | Tight |
| (S) | Sharp | (P) | Pins & Needles |
| (SB) | Stabbing | (ST) | Shooting |
| (AY) | Annoying | (SF) | Stiff |
| (B) | Burning | (TH) | Throbbing |
| (W) | Weak | (SP) | Superficial |
| (N) | Numb | (H) | Hot |
| (TG) | Tingling | (C) | Cold |
| (D) | Deep | Other: ______________ | |

*Mark with an "X" on the areas of your pain.*



Have you treated with this office in the past? ❑ Yes ❑ No

If you answered *"yes"* when? ______________

**ACCIDENT HISTORY:** Please explain the **details** leading up to the accident **below**. You may include diagrams.

**List the types of diagnostic testing that have been performed at any other facilities you received care from FOR THIS INJURY:**

❑ X-Rays ❑ Discogram ❑ CT Scan ❑ Bone Scan ❑ Myelogram ❑ EMG ❑ MRI

**Where were they performed?** ______________________________

**Specifics of Auto Accident:**

❑ Driver
❑ Front Seat
❑ Braced
❑ Head did strike object
❑ Head DID NOT strike object
❑ Air bag(s) deployed
❑ Flash of Light Seen on Impact
❑ Passenger
❑ Back Seat
❑ Not Braced
❑ Shock
❑ Car Towed
❑ Police Report Made

❑ Motor Vehicle Collision ❑ How many cars? _________
❑ Work Related ❑ Non-work Related
❑ Sports Related Incident
❑ Slip & Fall
❑ Other: ______________________________

**Social History:**

❑ Single
❑ Married
❑ Divorced
Number of Children: _________

Hobbies:

❑ Smoker
❑ Non-Smoker
❑ Drinks Alcohol Socially
❑ Does not drink alcohol
❑ Takes Drugs
❑ Does not take drugs

**Immediately following the incident:**

❑ Ambulance / Paramedics Called
❑ Treated at the scene
❑ Transported to Hospital by Ambulance
❑ Went to Hospital on your own *(**Date:**_________________)*
❑ Diagnostics performed at Hospital
❑ Medication Prescribed
❑ Treatment at *(**Hospital Name**___________________________)*
❑ Follow Up Recommended
❑ Other:

**Time Loss:**

❑ NO time loss from work due to injury, currently working with no limitations
❑ NO time loss from work due to injury BUT do have limitations
❑ Patient reports time loss due to injury. Indicate number of day(s) or week(s)
❑ N/A
❑ Date Last Work:_____/_____/ ____

**Occupational History:**
**What is your current job satisfaction?**

❑ Very Satisfied
❑ Satisfied
❑ Dissatisfied
❑ Very Dissatisfied
❑ N/A

❑ Any Disability Time?
❑ Limited / Light Duty
❑ Physically Demanding Work

❑ Highest Education Attained? ______________________

**Mechanism of Injury:**

| | | | | |
|---|---|---|---|---|
| Were you surprised by the impact? | ❑ Yes | ❑ No | | |
| In relation to the back of your head was your headrest set: | ❑ Low | ❑ Middle | ❑ High | |
| Where was your head facing at the time of impact? | ❑ Left | ❑ Forward | ❑Right | ❑ Unknown |
| Were you leaning forward at the time of impact? | ❑ Yes | ❑ No | | |
| Were you wearing a seat belt? | ❑ Yes | ❑ No | | |
| Were you rendered unconscious as a result of the incident? | ❑ Yes | ❑ No (***If yes, how long?*** ________________) | | |
| Did you feel pain immediately after the incident? | ❑ Yes | ❑ No (***If no, when?*** ________________) | | |

Year and type of vehicle you were in? Year:________________Make:__________________Model: ________________
Size of your vehicle ❑ Small ❑ Mid ❑ Large ❑ Unknown

Year and type of other vehicle involved? Year:________________Make:__________________Model:________________
Size of other vehicle ❑ Small ❑ Mid ❑ Large ❑ Unknown

What was the approximate speed of your vehicle when the incident occurred? ____________MPH
What was the approximate speed of the other vehicle when the incident occurred? ____________MPH
Do you have pictures of the damaged vehicles? ❑ Yes ❑ No

**Medical History:**

I have seen the following physician/professional for *this* condition:

Chiropractor:______________________________________

Massage Therapist: __________________________________

Orthopedist:_______________________________________

Physical Therapist: __________________________________

Physician:_________________________________________

Psychiatrist/Psychologist:____________________________

Other: ____________________________________________

**List the treatments you have had for this condition:**

❑ Ice
❑ Heat/Ultrasound
❑ Electrical Stimulation
❑ Exercises
❑ Traction/Decompression
❑ Bed Rest
❑ Chiropractic
❑ Osteopathy
❑ Injections
❑ Acupuncture
❑ Naturopathy
❑ Massage

**Current or Past Medical History:**

❑ Medication ❑ Surgery ❑ Hospitalization
❑ Previous Musculoskeletal Problems
❑ Other: ______________________________________

**Mark if you have had any of the following symptoms in the past 3 years:**

**B4 MVC – Before Motor Vehicle Collision**
**MVC – Motor Vehicle Collision**

| B4 MVC / MVC | | B4 MVC / MVC | | B4 MVC / MVC | | B4 MVC / MVC | |
|---|---|---|---|---|---|---|---|
| ❑ / ❑ | Unexplained fevers | ❑ / ❑ | Easy Bruising | ❑ / ❑ | Stomach Pain | ❑ / ❑ | Blood in Urine |
| ❑ / ❑ | Night Sweats | ❑ / ❑ | Excessive Bleeding | ❑ / ❑ | Changes in Bowel | ❑ / ❑ | Morning Stiffness |
| ❑ / ❑ | Weight Loss 10lbs+ | ❑ / ❑ | Lump in Neck, Armpit or Groin | ❑ / ❑ | Persistent Diarrhea | ❑ / ❑ | Eye Redness |
| ❑ / ❑ | Loss of Appetite | ❑ / ❑ | Chest Pain or Tightness | ❑ / ❑ | Excessive Constipation | ❑ / ❑ | Muscle Tenderness |
| ❑ / ❑ | Excessive Fatigue | ❑ / ❑ | Persistent/Unusual Cough | ❑ / ❑ | Dark Black Stools | ❑ / ❑ | Dry Eyes or Mouth |
| ❑ / ❑ | Problems w/ Depression | ❑ / ❑ | Trouble Breathing w/ Exercise | ❑ / ❑ | Bloody Stools | ❑ / ❑ | Skin Rashes |
| ❑ / ❑ | Difficulty Sleeping | ❑ / ❑ | Trouble Breathing Lying Flat | ❑ / ❑ | Pain/Burning when Urinating | ❑ / ❑ | Joint Pain/Swelling |
| ❑ / ❑ | Unusual Stress at Home | ❑ / ❑ | Cough Up Blood | ❑ / ❑ | Difficulty Urinating | ❑ / ❑ | Anxiety |
| ❑ / ❑ | Unusual Stress at Work | ❑ / ❑ | Swollen Ankles | ❑ / ❑ | Need to Urinate Frequently | ❑ / ❑ | Irritability |

**HEALTH HISTORY/INJURIES/TREATMENTS:**

**INJURIES YOU MAY HAVE HAD IN THE PAST** **DATES**

Auto Accidents: ____________________ ________

Work Injuries: ____________________ ________

Broken Bones: ____________________ ________

Other: ____________________ ________

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERED FROM:**

| | | | |
|---|---|---|---|
| ❐ Muscle Disorder | ❐ Asthma | ❐ Osteoarthritis | ❐ Coughing Blood |
| ❐ Nervous System Disorder | ❐ Broken Bones | ❐ Epilepsy | ❐ Circulatory Problems |
| ❐ Bone Disorder | ❐ Intestinal Problems | ❐ Alcoholism | ❐ Kidney/Bladder Problems |
| ❐ Rheumatoid Arthritis | ❐ Seizures/Convulsions | ❐ Drug Addiction | ❐ Heart Disease |
| ❐ Allergies | ❐ Congenital Disease | ❐ Strokes | ❐ Tumors |
| ❐ HIV | ❐ Excessive Bleeding | ❐ Cancer | ❐ Depression |
| ❐ Gallbladder Issues | ❐ High Blood Pressure | ❐ Ulcer | ❐ Ear/Throat Infection |
| ❐ Diabetes | ❐ Low Blood Pressure | ❐ Hernias | ❐ Pacemaker |

**SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION:** **DATE(S)**

Spine Surgeries: ❐ Discectomy ❐ Laminectomy ❐ Fusion ❐ Other: ____________________ ________

**NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION:**

❐ Medication ❐ Injections ❐ Physical Therapy ❐ Massage ❐ Chiropractic ❐ Acupuncture

❐ Other: ____________________

❐ Medication(s) Currently Being Taken: ____________________

❐ Female Patients: Most recent menstrual cycle: ____________________

❐ Pregnant: ____________________ ______ (weeks)

**************FOR DOCTOR USE ONLY BELOW THIS LINE. GO TO PAGE 6. ************

**HEENT**

❐ The patient is normocephalic, non-traumatic

❐ Pupils are equal, round and reactive to light & accommodation

❐ TM's are clear

**GASTROINTESTINAL**

❐ Abdomen is soft, non-tender

❐ Bowel sounds are normoactive

❐ No history or present complaints regarding gastrointestinal system

**CARDIOVASCULAR/PULMONARY**

❐ No complaints or history of heart murmur, blood pressure problems or other vascular disorders

❐ Heart exam reveals a regular rate with no murmurs, gallops or rubs

❐ Lungs are clear to percussion and auscultation

| | |
|---|---|
| | |
| **Blood Pressure** | **Pulse Rate** |

**GRIP STRENGTH:**

| | | |
|---|---|---|
| **Test 1** | RIGHT ______ | LEFT ______ |
| **Test 2** | RIGHT ______ | LEFT ______ |
| **Test 3** | RIGHT ______ | LEFT ______ |

**UROGENITAL**

❐ There is no complaint of frequency, urgency or difficulty w/ urination.

**NEUROLOGICAL EXAMINATION**

❐ Cranial nerves II-IX are grossly intact

❐ Romberg's Test

❐ Cerebellum function is grossly within normal limits

❐ Patient is alert and oriented to time, place and person

❐ Reflexes are equal and reactive bilaterally in both upper and lower extremities and are +2

DOCTOR'S INPUT: ❐ Wartenberg's pinwheel testing showed HYPERESTHESIA / HYPOESTHESIA

At dermatomal distributions ____________ on the RT / LFT

❐ Sensation is intact to all primary modalities

❐ Patient can heel and toe walk without difficulty

❐ Toes are down going and pathological reflex is absent for Babinski Sign

**Motor testing of the upper & lower extremity musculature revealed:**

**Grade: I, II, III, IV, V in the UPPER and/or LOWER extremities.**

**ORTHOPEDIC EXAMS**

| Test | | | | |
|---|---|---|---|---|
| Adson's Maneuver: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Anterior Drawer: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Apley's Compression: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Apley's Distraction: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Braggard's Sign: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Cervical Distraction: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Cozen's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Deep Inhalation Chest Pain: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Dugas' Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Ely's Heel Buttock Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Finklestien Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| George's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Hoover's Sign: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Kemp's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Laseque's SLR Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Magnuson's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Mankopf's Sign: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Max Cervical Comp: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| McMurray's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Mill's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| O'Donohue Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Patrick's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Phalen's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Schepelmann's Sign: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Shoulder Depression: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Straight Leg Raiser: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Supraspinatus Press: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Soto-Hall Test: | ❑ Positive | | ❑ Negative | |
| Valsalva Maneuver: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |
| Yergason's Test: | ❑ Left | ❑ Right | ❑ Bilateral | ❑ N/A |

❑ The performance of the malingering exams were negative and/or were not performed due to the positive integrity of the patient and/or due to the absence of examiner perceived needed.

| CERVICAL | Restrictive | Degree | Normal | Pain | Deficit |
|---|---|---|---|---|---|
| Flexion | ❑ | | 50 | | |
| Extension | ❑ | | 60 | | |
| Left Lat Flex | ❑ | | 45 | | |
| Rt Lat Flex | ❑ | | 45 | | |
| Left Rot | ❑ | | 80 | | |
| Rt Rot | ❑ | | 80 | | |

| LUMBAR | Restrictive | Degree | Normal | Pain | Deficit |
|---|---|---|---|---|---|
| Flexion | ❑ | | 50 | | |
| Extension | ❑ | | 25 | | |
| Left Lat Flex | ❑ | | 25 | | |
| Rt Lat Flex | ❑ | | 25 | | |
| Left Rot | ❑ | | 30 | | |
| Rt Rot | ❑ | | 30 | | |

**SPINAL EXAM**

❑ Spinal examination consisted of static and motion palpation of the cervical, thoracic, lumbar and pelvis (all or separate)

It included:

- ❑ Intervertebral joint play analysis
- ❑ Comparative leg length analysis
- ❑ Range of Motion Evaluation

**ARTICULAR DYSFUNCTION**

These articular dysfunctions are associated & accompanied by:

- ❑ Joint Edema
- ❑ Joint Capsulitis
- ❑ Deep & Superficial Myospasms

❑ There is muscle splinting and tenderness upon digital palpation at the levels of articular dysfunction.

❑ There is pain on percussion of the spinous processes at these levels as well

**The examination revealed dysfunctions/vertebral subluxations at the following levels:**

**C** 0 1 2 3 4 5 6 7 **T** 1 2 3 4 5 6 7 8 9 10 11 12 **L** 1 2 3 4 5 **Sacrum Ilium R L**

There are myofascial trigger points located in the following musculature:

Radiology:

**UPPER EXTREMITY:**

**LOWER EXTREMITY:**

**OTHER:**

**CAUSATION:**

❑ In my opinion, the above diagnoses are a direct result of the Date of the Incident noted above.

Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ❑ Yes ❑ No ❑ If "No," please explain:

Is there any other current condition that will impede or delay patient's recovery? ❑ Yes ❑ No ❑ If "Yes," please explain:

**PLAN/RECOMMENDATIONS:**

❑ 4 times/week ❑ Once a week

❑ 3 times/week ❑ Every 2 weeks

❑ 2 times/week ❑ Once a month

Patient will be re-evaluated in:

❑ One month ❑ 2 weeks

❑ 1 week ❑ 3 weeks ______ Visits

❑ Chiropractic Adjustments (CMT), Activator (ACT), Neuromuscular Re-Education (NR), Joint Mobilization (JM), Myofascial Release (MR), Intersegmental Traction (IT), Electrical Stimulation (EMS), Mechanical Message (MM), Ultrasound (US), Diathermy (D), Hot/Cold Pack (HP/CP), Interferential (ITF) Transcutaneous Nerve Stimulation (TENS), Infrared (IF), Therapeutic Exercises/Outside Office (TE)/(TEO), Physician's Education Group (PEG)

❑ The patient's condition has stabilized. I have recommended periodic chiropractic check-ups in order to maintain the patient's progress.

Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C. | John Chapman, D.C.

# HEAD TRAUMA EVALUATION

**Patient Name:** ______________________

**Please fill in all symptoms you currently have that you did not have before the accident.**

**Neurological Symptoms**

- ❒ Numb /tingling arm/hand L R
- ❒ Numb/tingling leg/foot L R
- ❒ Weakness arm/hand L R
- ❒ Weakness leg/foot L R

**Symptoms Associated with Injuries**

- ❒ Range of motion problems
- ❒ Headaches
- ❒ Muscle spasms
- ❒ Dizziness
- ❒ Visual disturbances
- ❒ Sleep disruption
- ❒ Radiating pain
- ❒ Anxiety
- ❒ Depression
- ❒ I am taking over-the-counter pain meds

**Brain/Neuropsych/MTBI Symptoms**

- ❒ Wanting to be alone
- ❒ Sleepiness
- ❒ Nausea/vomiting
- ❒ Difficulty concentrating
- ❒ Daydreaming/Mindless Staring
- ❒ Mood swings
- ❒ Difficulty learning new things
- ❒ Agitation
- ❒ Difficulty remembering things
- ❒ Re-reading things to understand
- ❒ Disoriented
- ❒ Confused
- ❒ Difficulty speaking
- ❒ Feelings of isolation from others
- ❒ Attention problems
- ❒ Appetite change
- ❒ Pupils different size
- ❒ Fatigue
- ❒ Rooms spins/woozy feeling
- ❒ Balance problems
- ❒ Difficulty walking
- ❒ Difficulty focusing/easily distracted
- ❒ Difficulty planning organizing
- ❒ Personality Change
- ❒ Can't remember numbers
- ❒ Reading problems
- ❒ Writing problems
- ❒ Difficulty with adding/subtracting
- ❒ Poor attention
- ❒ Difficulty understanding
- ❒ Sadness or tearful
- ❒ Blurry/Double vision
- ❒ Anger
- ❒ Difficulty making decisions
- ❒ Change in sensual functioning
- ❒ Reduced confidence
- ❒ Helplessness
- ❒ Apathy (Don't care)
- ❒ Irritable
- ❒ Change in the sense of taste smell
- ❒ Flashbacks to accident
- ❒ Impatience
- ❒ Frustration
- ❒ Hearing problems

Sheridan Chiropractic, Inc.
26900 Newport Rd. Ste. 110, Menifee, CA 92584 | P. (951) 672-8060 | F. (951) 672-7490
Shamus Sheridan, D.C. | Sean Sheridan, D.C.

# NOTICE OF DOCTOR'S LIEN

**Patient**: ______________________________ **Date of Accident**: ____________

I do hereby authorize **Sheridan Chiropractic, Inc.,** to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct to you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service(s) rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

**Dated**: ____________

______________________________
**Patient Signature**

______________________________
**Printed Name**

The undersigned being attorney of record for the above patient does hereby agree hereby agree to observe all of the terms above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said the doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and cost.

**Dated**: ____________

______________________________
**Attorney Signature**

______________________________
**Attorney Printed Name & Law Firm**

# Sheridan Chiropractic, Inc. Consent to Services

**PATIENT RIGHTS** **PT INITIALS** ________

Sheridan Chiropractic, Inc. (SCI) respects the unique differences of our patients, and will ensure that healthcare ethics are maintained for all patients. The following rights will be exercised in our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

**CONSENT TO TREATMENT OF A MINOR CHILD *(UNDER THE AGE OF 18)*** **PT INITIALS** ________

I authorize chiropractic and/or physical therapy care as deemed necessary to my (relationship) ____________________.

**FEMALE PATIENTS *(ONLY)*** **PT INITIALS** ________

This is to certify that, to the best of my knowledge, I am NOT pregnant and that SCI has my permission to take x-rays. Beginning date of last menstrual period ________________.

**PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME** **PT INITIALS** ________

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid it directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

**CONSENT TO X-RAY ASSIGNMENT AGREEMENT** **PT INITIALS** ________

I consent to allow SCI to use the services of an outside radiologist if needed to ensure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for the services will be submitted to my insurance carrier, Workers' Compensation carrier of State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the radiologist or radiology services.

I assign my insurance benefits and rights to payment to the radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide the radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

**CONSENT TO CHIROPRACTIC AND/OR PHYSICAL THERAPY SERVICES** **PT INITIALS** ________

I hereby request and consent to comprehensive examinations (chiropractic and/or physical therapy, orthopedic, and/or neurological), chiropractic adjustments/treatments (and other procedures including various modes of physiotherapy modalities), physical therapy intervention (including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program), nutritional counseling/advice, and diagnostic x-rays by SCI (& it's staff), who now or in the future treat me in this office. I have had an opportunity to discuss with the SCI Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of physical therapy there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feel at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future condition(s) for which I seek treatment by SCI and/or employed staff.

**NO-SHOW/CANCELLATION/LATE POLICY** **PT INITIALS** ________

Patient agrees to notify SCI regarding any missed appointments. Patient will respectfully agree to cancel within 24 hours of scheduled time. If patients show up for appointments more than 15 minutes late we may reschedule or full treatment will not be given.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

**Printed Name:** ____________________ **Signed:** ____________________ **Dated:** ____________________

**PATIENT NAME:** ______________________________

## ARBITRATION AGREEMENT AND INFORMED CONSENT

**Article 1: Agreement To Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration and procedural disputes will also be determined by submission of binding arbitration. It is the intention of the parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the healthcare provider's clinic(s) or office(s) or any other clinic or office whether dignitaries to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care providers' associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive belief or punitive damages.

**Article 3: Procedures And Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this arbitration agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable state statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement.

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, weather signatories to 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.

**Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article 1 of this contract.**

**PATIENT SIGNATURE:** ______________________________ **DATE:** ____________________