Innereye Chiropractic, Dr. Jason Fleischer, D.C.
1609 Westover St. Gastonia, NC
Inside Ultimate Fitness Gym
www.innereyechiro.com
Phone: 704-751-2042
Email: drfleischerdc@gmail.com

Informed consent for examination and treatment & privacy policy

I hereby request and consent to the performance of chiropractic adjustments, orthopedic examination, any recommendations to the supplement of their plan of care within the chiropractic scope, and any other chiropractic procedures, (or on the patient name below, for whom I am legally responsible), by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I understand that if necessary, diagnostic imaging will be referred out and done by an imaging specialist before any chiropractic treatment is administered.

I further understand that such chiropractic services may be performed by the physician at Innereye Chiropractic and/or other licensed physicians of chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the chiropractic physician and/or with other office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carry some risks to treatment which include rarely, but not limited to: fractures, disc injuries, dislocations, and sprains/strains, stroke, and death. I do not expect the physician to be able to anticipate and explain all risks and complications. Rather, I wish to rely on the physician to exercise judgment during the course of the procedure which is the physician feels are in my best interest at the time, based upon the facts then known.

I understand that adjustments may be administered in an open practice setting or within closed doors, (available at only certain locations). I understand that I will inform the physician if other arrangements need to be made concerning my privacy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agreed to the treatment recommended by the physician. I intend this consent form to cover the entire course of treatment for my present conditions and for any conditions for which I see treatment at this facility.

To be completed by the patient. If necessary, to be completed by the patient representative (e.g. if the patient is a minor or is physically or mentally he incapacitated)

______________________	______________________	____________
Print Patient's Name	Patient Signature	Date
______________________	______________________	____________
Print Name of Representative	Representative Signature	Date

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Patient Information and Health History

Name_______________________________________Sex M F Date________________________

Address____State______________Zip________________

H. Phone(________)_________________W. Phone_________________ Date of Birth______________ Age_________

Referred by____Social Security #_____________________________

Occupation____ Employer_____________________________________

Have you ever received Chiropractic Care? Yes No If yes, when?_________________________________

1. Primary reasons for seeking chiropractic care:

Primary reason: ____

Secondary reason: ____

Other factors contributing to the primary and secondary reasons: ______________________________________

2. Chief Complaint: ____

Location of Complaint: ____

Complaint Began when and how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_________________________

Do you have any numbness or tingling in your body? Where? ____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ____

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: ______________

____

____

4. Past Health History:

A. Previous illnesses you've had in your life: ____________________

____

B. Previous injury or trauma: ____________________

____

Have you ever broken any bones? Which? ____________________

C. Allergies ____________________

D. Medications:

____

____

Reason for taking Medication

____________________ ____________________

____________________ ____________________

E. Surgeries:

Date	Type of Surgery

5. Family Health History:

Associated health problems of relatives: ____________________

____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

A. Job description: ____________________

B. Work schedule: ____________________

C. Recreational activities: ____________________

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): ____________________

____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient's Signature ____________________ Date ____________________

Doctor's Signature ____________________ Date ____________________