Personal Injury/ Auto Accident

KENT MILLER, D.C. www.millerchiropractic.org **3504 W Davis St**
FAX:855-460-7005 PHONE:936-788-6565 **Conroe,TX 77304**

CONSENT FOR TREATMENT

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic x-rays on the named patient, 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 work at the Miller Chiropractic . I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctor of chiropractic named below and/or with other clinic personnel. I understand that results are not guaranteed. I understand that in the practice of chiropractic, as in the presence of medicine, there are some risks. I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely upon the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time is in the patient's best interest, based upon the facts then known to him or her. I have also had the opportunity to ask questions about is 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 the present condition and for any future condition(s) for which I seek treatment.

_____ _____
Patients Signature **Date**

_____ _____
Parent or guardian Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Protection* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes and,
- The right to request restriction as to how my health information maybe used or disclosed to carry out treatment, payment, or health care options.

_____ _____
Patients Signature **Date**

_____ _____
Parent or guardian Signature **Date**

CONTENT TO TREAT MINOR

I hereby authorize the doctor(s) at Miller *Chiropractic* and whom ever they designate as assistants to administer care to child.

Name of Child/ Minor: _____

Name of Parent/ Guardian:_____

_____ _____
Parent or guardian Signature **Date**

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Patient registration

Please answer all applicable question, leave blank if not applicable

Name_____MI_____**Last Name** _____

DOB _____(MM/DD/YYYY) **Gender**(Circle Answer): Male Female Other

Email_____

Address _____

City_____**State**_____**Zip** _____

Cell Phone_____**Home Phone** _____

Emergency Contact Name:_____

Relation: _____ Phone # _____

Patient employer: _____

Have you lost any time from work?(Circle Answer) Yes No

Do you need a note for work?(Circle Answer) Yes No

Do you have a **Pacemaker** or **defibrillator?**(Circle Answer) Yes No

Height :_____ Weight : _____

For **Females:** (Circle Answer)

Are you pregnant? Yes No Do you take birth control pills? Yes No

Date of accident/Incident:_____-_____-_____ **MM-DD-YYYY**

Did you go to **Hospital/ER** for your accident?(Circle Answer) Yes NO (leave blank if not applicable)

Please list **NAME of Hospital or ER**_____

If you went at a later date than accident please list here (MM-DD-YYYY) _____- _____- _____

How did you get to the hospital:_____

Medication prescribed:_____

_____

Did you receive any of these tests ? (Circle any tests apply)

MRI CT Scan X-ray Ultrasound

Personal Injury/ Auto Accident

Accident/Incident Type(Circle Answer):

18 wheeler Rear-ended Accident Head-on collision Sideswiped accident

T-Bone Accident Slip & Fall

Was there a **police report** filed:(Circle Answer) Yes NO

Were you wearing a **seat belt**? (Circle Answer) None Shoulder Harness Lap belt

Was airbag deployed:(Circle Answer) Yes NO

Your role was:(Circle Answer)

Driver of Vehicle Driver of motorcycle Back seat passenger Front seat passenger

Please describe the Accident/Incident: _____

_____

_____

_____

_____

Place of Incident(if slip & fall): _____

Did you Report the Incident?(if slip & fall)(Circle Answer) YES NO

(If yes to whom)?_____

Write your description of what you are feeling: _____

_____

_____

_____

Are you experiencing any of the following since your injury? (Circle all that apply)

Anxiety	Ankle/Foot Pain	Blurry vision	Breathing Problems
Chest Pain	Dizziness/Loss of balance	Elbow Pain	Fatigue
Hip Pain	Headaches	Knee Pain	Low Back Pain
Memory lapses	Mid Back Pain	Neck Pain	Numbness/Tingling to Arm/Hand
Numbness/Tingling to Leg/Foot	Shoulder Pain	Upper Back Pain	Wrist/Hand Pain

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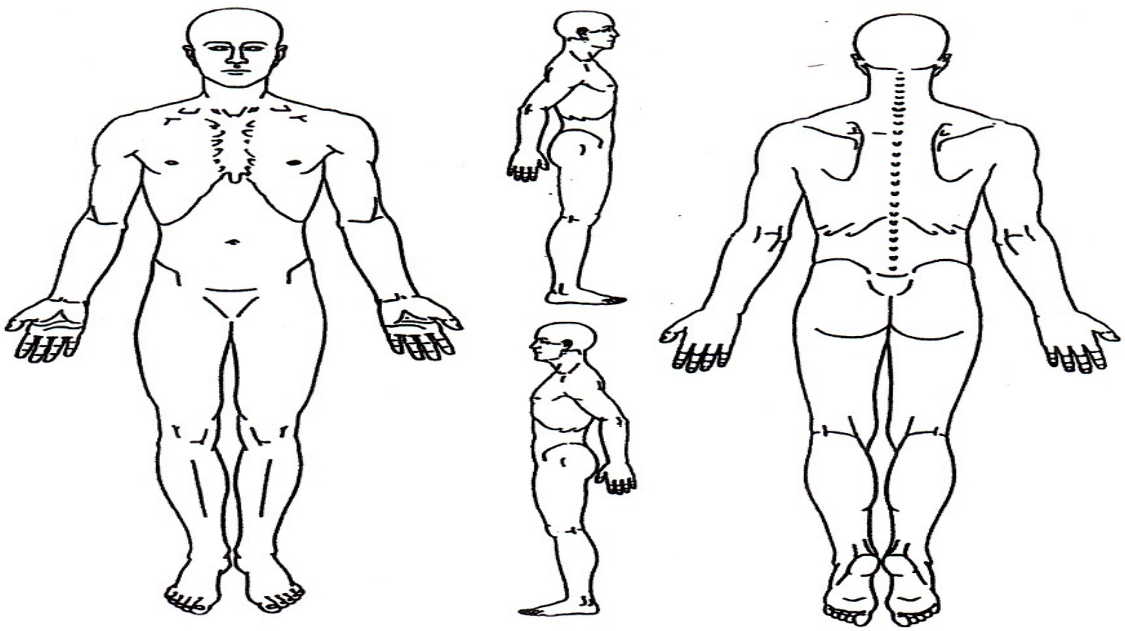
Circle all that apply:

Indicate on the diagrams below the location/s on body and circle type of sensation/s you have been experiencing. Circle all that apply:

Ache	Burning	Cramping	Dull	Numbness
Sharp	Shooting	Spasm	Stiff	Stinging
Tingling	Throbbing			

Other_____

Indicate(X or circle) on diagram the pain location:



I **UNDERSTAND** and **AGREE** to authorize Dr. Miller and his employees to administer any examination procedures and treatments as they deem necessary.

Signature _____**DATE** _____