Miller Chiropractic

Kent Miller, D.C.

PHONE:936-788-6565 FAX:855-460-7005

3504 W Davis St Conroe,TX 77304

www.millerchiropractic.org

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

Name____________________________MI_______Last Name ____________________________

DOB ____________________________ Gender: Male Female Other

Driver license #: ________________________ SSN:______________________

Email____

Address ____

City________________________________State__________Zip ________________

Cell Phone__________________________Home Phone __________________________

Emergency contact name ____

Phone________________________

Relationship ____

Marital Status (Circle Answer): Single Married Separated Divorced Widowed

Patient employer:____

Have you lost any time from work? Yes No

Do you need a note for work? Yes No

Have you seen any other doctors for this condition? Yes No

Who? ________________________________ Phone:__________________

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MEDICAL HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past:

	Abdominal		Depression		Kidney Disease		Sciatica
	Alcoholism		Diabetes		Liver disease		Short of breath
	Allergy		Dizziness		Mental disease		Sinus trouble
	Anemia		Gall bladder		Migraines		Sleeplessness
	Arthritis		Gout		Multiple sclerosis		Stress
	Asthma		Gynecological		Nausea		Stroke
	Cancer		Headaches		Neck pain		Thyroid problems
	Cataracts		Hearing Trouble		Osteoporosis		Tumors, Growths
	Chest pain		Heart disease		Parkinson’s disease		Ulcers
	Cold hands/feet		Hemorrhoids		Polio		Varicose veins
	Colds/infections		Hardening of arteries		Poor appetite		Vision problems
	Colon trouble		Hepatitis		Prostate		Poor appetite
	Constipation		Herniated Disc		Rheumatoid		Weight Gain/Loss
	Concussion		High Cholesterol		Scarlet fever		Whooping cough

Do you have a **Pacemaker** or **defibrillator**? ____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

____

____

____

WOMEN ONLY:(Circle Yes or NO)

Currently Pregnant? Yes No Painful /Abnormal Menstrual Cycle? Yes No

Do you have children? Yes No If “Yes”, type of birth? Circle Vaginal or C-Section

Epidural: Yes No Date: _______________________

Menopause? Yes No

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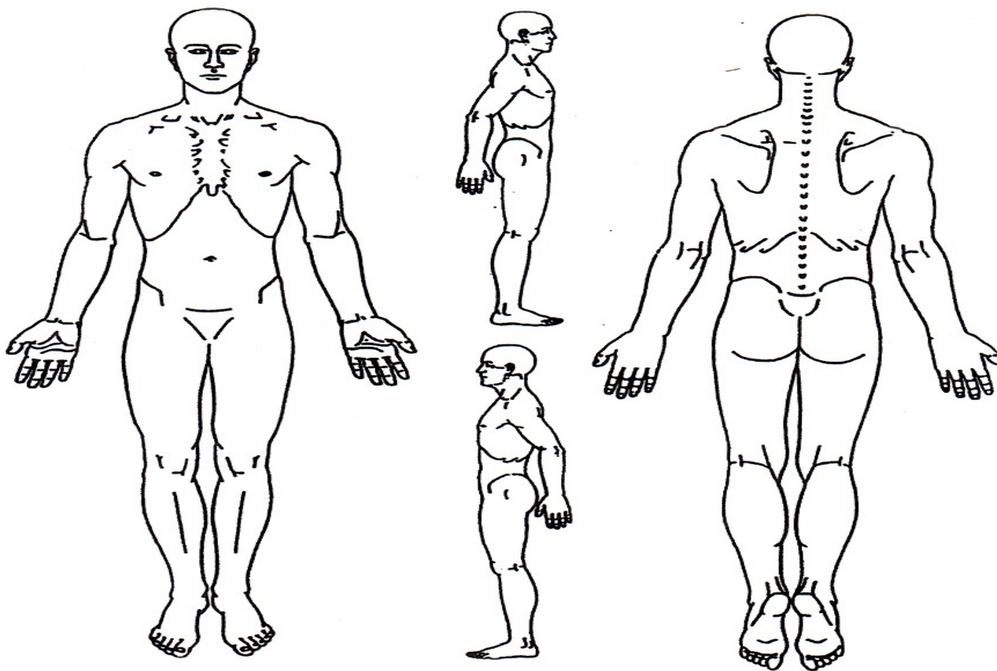
Indicate on the diagrams below the location/s on body and circle type of sensation/s you have been experiencing. Circle all that apply:

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

Other______________________________

Mark where pain is:



Please describe complaints and start Date : ____/_____/_______

____

____

____

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

Signature ____**DATE** __________