

LAKEWOOD CHIROPRACTIC
2434 N WOODLAWN STE 170
WICHITA, KANSAS 67220

DATE _____
DR: MK WS SS VW EW

NAME: _____ Prefer to be called: _____ Sex Male Female

Home Address _____ City _____ State _____ Zip _____

Birthdate / / Age _____ Marital Status: S M D W SSN# _____ Spouse's Name _____

Home Phone _____ Cell Phone _____ E-mail Address _____

What is the best time of the day to contact you and at what telephone number? _____

Ages of Children _____ Referred to our office by or how did you hear of our clinic: _____

Employer _____ Occupation _____ How Long? _____

Work Phone _____ Daily Duties/Activities _____

Is your pain due to an **AUTO** accident or a **WORK** injury? Filing to Auto Insurance Yes No / Filing to Work Comp Yes No

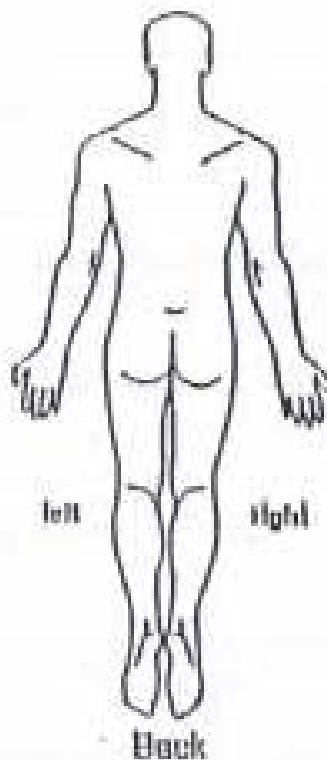
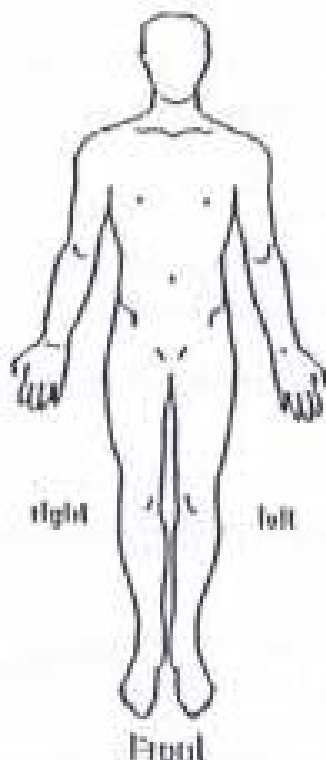
What made you seek our care? _____ How long has it hurt? _____

What do you think is the cause of your pain? _____

RATE THE INTENSITY OF YOUR PAIN

1 2 3 4 5 6 7 8 9 10
No pain Discomfort Excruciating

A=Achy B=Burning
N=Numbness
P=Pins & Needles
S=Stabbing



PATIENTS SIGNATURE _____

LAKWOOD CHIROPRACTIC L.L.C.
2434 N. Woodlawn ste #170
Wichita, Kansas 67220

DATE: _____
DR. M M T S S T W T U

Name _____

DOES YOUR PAIN INTERFERE WITH: **WORK** **SLEEP** **DAILY ROUTINE**

Have you been treated by a Dr./Hospital for this condition? Yes No

Have you ever had this or a similar condition in the past? Yes No

Family Dr. : _____ Last Visit: _____ Reason: _____

Height _____ ft _____ in. Weight _____ lbs Do you smoke/how much? _____

Please list ANY medication that you take, and what it is for:

Have you ever been to a Chiropractor before? yes no X-rayed? yes no _____

Last adjustment: _____ Areas adjusted: _____ Any therapy? _____

Any comments you would like to share about your previous care: _____

What do you do for exercise/pleasure/hobbies: _____

VITAMINS you take: _____

SLEEP POSTURE: Side Back Stomach **PILLOWS:** # _____ Flat _____ Medium _____ Thick _____

ARE YOU WEARING: _____ Heel lifts _____ Arch supports _____ Insoles _____ Shoe heel built up _____

HEALTH HISTORY (Please mark with an X)

	YOURSELF	Mother	Father	Brother	Sister
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart	_____	_____	_____	_____	_____
Kidney	_____	_____	_____	_____	_____
Lung	_____	_____	_____	_____	_____
Mental	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____

Patient Signature _____

NAME: _____

Any other stressors that will affect your improvement _____

LIST PREVIOUS **SURGERIES**/YEAR PERFORMED: _____

LIST ANY **PAST TRAUMAS** THAT MIGHT BE AFFECTING YOUR HEALTH: _____

WOMEN: ARE YOU PREGNANT? Yes No DUE DATE _____ DR. _____

LAST MENSTRUAL CYCLE _____ BIRTH CONTROL? _____

MOST RECENT PELVIC/PAP _____ Mammogram _____ ? Menopause _____

MEN: HAVE YOU HAD A PROSTATE EXAM ? Yes No 199__ 200__

I give permission to my chiropractor to release his/her findings to my family physician and obstetrician.

yes _____ Please Initial

AUTHORIZATION FOR RENDERING/PAYMENT OF SERVICES

I authorize the staff to perform any necessary services needed during diagnosis and treatment and to release of any information required to process insurance claims.

I understand my insurance is filed as a courtesy and I AM RESPONSIBLE FOR THESE SERVICES !

**I UNDERSTAND THAT I AM EXPECTED TO PAY
MY CO-PAY OR INSURANCE % & ALL TAKE HOME ITEMS
AT EACH VISIT!**

If these services are not paid in full within 60 days of the date of service and no other financial arrangements have been made I will be responsible for legal fees, collection agency fees, interest and any other expenses incurred in collecting my account.

I understand the above information and guarantee these 3 pages were completed to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Date

Patient Signature

LAKWOOD CHIROPRACTIC L.L.C.
2434 N. Woodlawn Ste 170
Wichita, KS 67220

DATE _____
DR. EW MK SS WS VW

NAME: _____

IF WE ARE FILING INSURANCE AND YOU ARE NOT THE PRIMARY :

INSURED'S NAME: _____ BIRTHDATE: _____

INFORMED CONSENT TO TREATMENT

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 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 WORK AT THE CLINIC OR OFFICE LISTED ON THIS PAGE.

I HAVE/OR WILL HAVE THE OPPORTUNITY TO DISCUSS WITH THE DOCTOR OF CHIROPRACTIC NAMED BELOW AND/OR WITH OTHER OFFICE OR CLINIC PERSONNAL THE NATURE AND PURPOSE OF CHIROPRACTIC ADJUSTMENTS AND OTHER PROCEDURES. I UNDERSTAND THAT RESULTS ARE NOT GUARANTEED.

I UNDERSTAND AND I AM NOW 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 UPON THE DOCTOR TO EXERCISE JUDGEMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN TO HIM OR HER, IS IN MY BEST INTEREST.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I UNDERSTAND I HAVE THE OPPORTUNITY TO ASK QUESTIONS ABOUT THIS CONSENT AND ITS CONTENT PRIOR TO TREATMENT, 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 FUTURE CONDITION (S) FOR WHICH I SEEK TREATMENT.

PATIENT'S SIGNATURE _____ DATE _____

WITNESS NAME _____ DATE _____

WITNESS SIGNATURE _____