Thank you for choosing Community Chiropractic to serve you quality care. To help us help you, please complete the following carefully.

Patient Information

First and Last Name: _____ Date of Birth: _____

Mailing Address: _____ Home number: _____

City and Zip: _____ Cell Number: _____

Responsible for Payment (If different than above)

First and Last Name: _____ Relation to patient: _____

Mailing Address: _____ Cell Number: _____

City and Zip: _____

Emergency Contact Information

First and Last Name: _____ Home number: _____

Relation to patient: _____ Cell Number: _____

Payment Information

Do you have insurance that covers chiropractic care? Please Initial

_____ No. I agree to pay for care at the time of service

_____ Yes. (please provide copy of Insurance card)

Federal Health Records Initiative

The government has asked that we inquire the following information. **You may decline to answer any and all of the following questions**. We will treat the following answers with the same confidentiality as your medical records.

SSN: _____

Martial Status: _____

Primary Language: _____

Race: _____

Ethnicity: _____

Mother's Maiden Name: _____

Your Birth State: _____

COMMUNITY CHIROPRACTIC FAMILY WELLNESS

CURRENT COMPLAINTS- Please list in order of severity

Main complaint: _____

Date problem started: _____

Location: _____

Quality: (ex. aching, stabbing, burning, etc): _____

Intensity of symptoms(0 being none, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

What increases symptoms? _____

What decreases symptoms? _____

Past Injuries: _____

Health history: _____

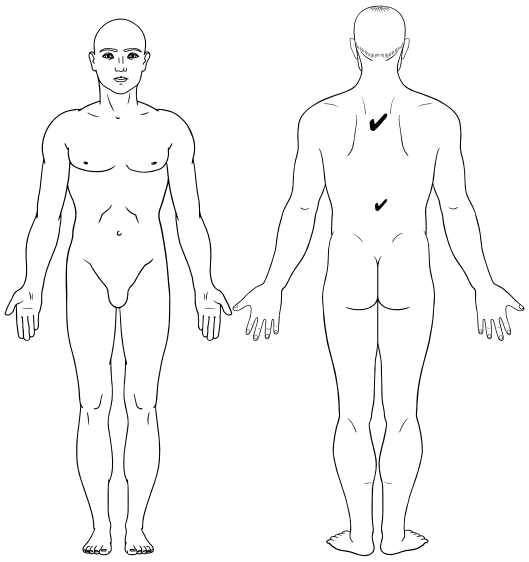
_____

_____

_____

Additional information:

Please mark areas of pain below



2nd complaint: _____

Date problem started: _____

Location: _____

Quality: (ex. aching, stabbing, burning, etc): _____

Intensity of symptoms(0 being none, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

What increases symptoms? _____

What decreases symptoms? _____

Past Injuries: _____

Health history: _____

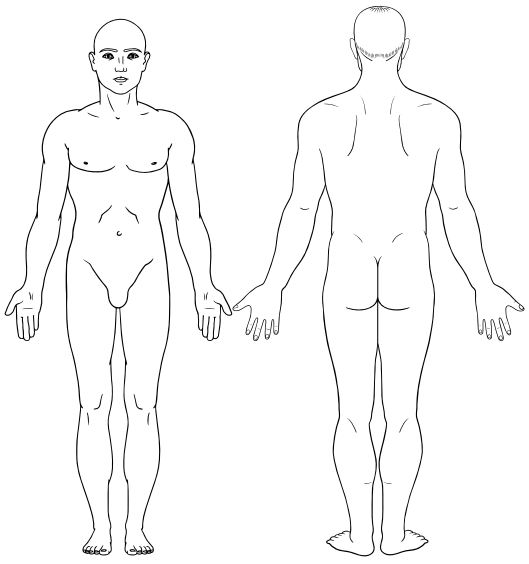
_____

_____

_____

Additional information:

Please mark areas of pain below



3rd complaint: _____

Date problem started: _____

Location: _____

Quality: (ex. aching, stabbing, burning, etc): _____

Intensity of symptoms(0 being none, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

What increases symptoms? _____

What decreases symptoms? _____

Past Injuries: _____

Health history: _____

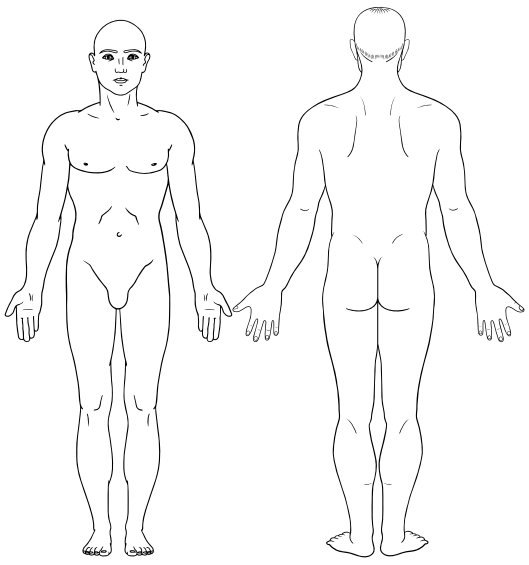
_____

_____

_____

Additional information:

Please mark areas of pain below



COMMUNITY CHIROPRACTIC FAMILY WELLNESS

Your care and privacy is important to us. Please read the following consents carefully before signing. Text reminders, photo release and emails are optional. Please note, if you opt out of texts, you will not receive appointment reminders.

Privacy Policy

We are required by law to exercise reasonable caution with regard to your health information. Your signature below acknowledges that our privacy policies are available to you and you understand your rights.

_____ _____

Signature Date

Cancellation/No Show Policy

If an appointment is not cancelled within a reasonable amount of time you will be charged a $25 fee that will not be covered by your insurance

_____ _____

Signature Date

Text Reminders

I, _____ give my permission for Community Chiropractic to send me text reminders regarding any appointments

_____ _____

Signature Date

Photo Release

I, _____ give my permission for Community chiropractic to use pictures or videos of my care on their social media accounts. You will always be aware before any photos/recording take place.

_____ _____

Signature Date

Email List

I, _____ give my permission for Community Chiropractic to add my to Dr. Lund's email list to recive updates and information

_____ _____ _____

Signature Email Date

COMMUNITY CHIROPRACTIC FAMILY WELLNESS

Informed Consent For Chiropractic Treatments and Care

To the patient (or their legal guardian): By signing the bottom of this form, you are acknowledging you have read it in it's entirety and had the opportunity to ask any questions about it's content. By signing you are agreeing to the below named procedures.

Chiropractic Adjustments

The primary treatment rendered by the Doctor of Chiropractic to you are adjustments. Chiropractic adjustments have the desirable effect of enabling muscles, tendons and ligaments to properly function and heal. Chiropractic adjustments can be made by either the use of the doctor's hands or mechanical instruments to any bone or joint in the body, including both spinal and extremity bones. You may or may not hear audible sound during your adjustment, which is just air being released from the joint space, as bones are moved into their proper positions.

Material risk Inherent with Chiropractic Adjustments and Treatments

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, costovertebral strains and separations, and burns. Some patients experience stiffness and/or soreness following the first few days of treatment. Dr. Tamara Lund will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the doctor of any conditions that would not otherwise come to her attention.

I understand that I will have the opportunity to discuss with Dr. Lund and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommendations and can have my questions answered to my satisfaction before treatment begins.

Alternatives to Chiropractic Care

Other treatment options for your condition may include rest, acupuncture, physical therapy, medical care, medications and/or supplements, hospitalization, and others. If you choose to use other treatment options, you should discuss the risks and benefits with your medical doctor or other provider.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM

_____ _____

Signature of patient or legal guardian Date

_____

Printed Name