DE MELO CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name _____ DOB _____ HR#: _____

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please explain in detail how your accident happened. _____
_____
_____
_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____
_____
_____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset		

Symptoms other than above: _____
_____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____How long? _____

Name of Hospital_____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes/ No

Patient's Name **DOB** **HR#:**

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms, Improving? Getting worse? Same?

Drive of other vehicle (if any)

Name_____Insurance Company_____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name_____ Insurance Company_____Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes/ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____(street or highway)

Other vehicle was heading North/ East/ South/ West on _____(street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts_____

Patient's Name DOB HR#:

Patient signature DATE

Doctor signature DATE

Lumber/Knee/Hip regions DATE_____

DE MELO CHIROPRACTIC CLINICAL EXAMINATION FINDINGS

PATIENT'S NAME:_____ **DOB:** _____ **HR#:**_____

1. Patient is alert and oriented to time, place & person: **Yes** **No**
2. **Mood and affect:** Depression Anxiety Agitation Non-contributory
3. **Lumbar ROM** (Normal in parenthesis)
   Flexion (90) _____ L Lateral Flexion (30) _____
   Extension (30) _____ R Lateral Flexion (30) _____
4. **Knee ROM** Flexion (140) _____ Extension (10) _____
5. **Hip ROM** Flexion (125) ____ Internal Rotation (40) ____ Abduction (145) _____
   Extension (30) ____ External Rotation (60) ____ Adduction (25) _____

6. Muscle Strength

Muscle	R. Strength	L. Strength
Hip Flexion	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip AB	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip AD	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Knee Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Knee Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Ankle D. Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Ankle P. Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**

☐ All Tests = WNL (5)

7. Reflexes

Reflex	Grade
L Patellar	0 1 **2** 3 4
L Achilles'	0 1 **2** 3 4
R Patellar	0 1 **2** 3 4
R Achilles'	0 1 **2** 3 4

☐ **All Tests WNL (+2)**

8. Dermatomes

Level	↑	N	↓	Notes
L3				
L4				
L5				
S1				

L=left R=right ☐ **All Tests WNL**

9. Palpation

Area	L/R	Pain	Spasm	T.P. A	T.P. L
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		

S=sharp D=dull

10. Orthopedic Tests

	Test	Findings				Notes
☐	SLR	+	–	R	L	at °
☐	Braggard's	+	–	R	L	
☐	Faber-Patrick	+	–	R	L	
☐	Kemp's	+	–	R	L	
☐	Valsalva's	+	–	R	L	
☐	Yeoman's	+	–	R	L	
☐	Ely's	+	–	R	L	
☐	Toe Walk	+	–	R	L	
☐	Heel Walk	+	–	R	L	
☐	Sacral Apex	+	–	R	L	
☐	Erichsen's	+	–	R	L	
☐	Abduction Str.	+	–	R	L	
☐	Adduction Str.	+	–	R	L	
☐	Apprehension	+	–	R	L	
☐	Drawer Sign	+	–	R	L	

11. Posture

Area	Findings
F H P	+ –
Head Tilt	R L
Head Rot.	R L
↑ Shoulder	R L
Thor. Tilt	R L
Thor. Trans.	R L
↑ Hip	R L
Hip Rot.	R L
Foot Flare	R L

12. Asymmetry/Misalignment/ Subluxations:

Diagnosis:

1-

2-

3-

4-

5-

Notes:

Examiner/Doctor Signature Date

JDD, DC 5/2011

Cervical/Thoracic/Shoulder regions DATE _____

DE MELO CHIROPRACTIC CLINICAL EXAMINATION FINDINGS

PATIENT'S NAME:_____ **DOB:** _____ **HR#:**_____

1. Patient is alert and oriented to time, place & person: **Yes** **No**
2. **Mood and affect**: Depression Anxiety Agitation Non-contributory
3. **Cervical ROM** Flexion (50) _____ Extension (60) _____ L Lateral Flexion (45) _____ R Lateral Flexion (45) _____ L Rotation (80) _____ R Rotation (80) _____
4. **Thoracic ROM** Flexion (50) _____ L Rotation (30) _____ R Rotation (30) _____
5. **Shoulder ROM** Flexion (180) _____ Extension (60) _____ Internal Rotation (75) _____ External Rotation (90) _____ Abduction (150) _____

6. Muscle Strength

Muscle	R. Strength	L. Strength
Biceps	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Brachio	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Wrist Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Triceps	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Finger Ext.	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Finger Ab / Ad	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Grip	0 1 2 3 4 **5**	0 1 2 3 4 **5**

☐ **All Tests = WNL (5)**

7. Reflexes

Reflex	Grade
L Biceps	0 1 **2** 3 4
L Triceps	0 1 **2** 3 4
L Brachio	0 1 **2** 3 4
R Biceps	0 1 **2** 3 4
R Triceps	0 1 **2** 3 4
R Brachio	0 1 **2** 3 4

☐ **All Tests WNL (+2)**

8. Dermatomes

Level	↑	N	↓	Notes
C5				
C6				
C7				
C8				
T1				

L=left R=right ☐ **All Tests WNL**

9. Palpation

Area	L/R	Pain	Spasm	T.P. A	T.P. L
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		
			0 1 **2** 3 4		

S=sharp D=dull

10. Orthopedic Tests

	Test	Findings				Notes
☐	George's	+	–	R	L	
☐	Distraction	+	–	R	L	
☐	Max. Comp.	+	–	R	L	Ipsi / Contra
☐	O'Donahue's	+	–	R	L	
☐	Soto Hall	+	–	R	L	
☐	Shoulder Dep.	+	–	R	L	
☐	Valsalva's	+	–	R	L	
☐	Spinal Perc.	+	–	R	L	Level
☐	Finger / Nose	WNL		BNL		
☐	Adson's	+	–	R	L	
☐	Schepelmann	+	–	R	L	
☐	Bowstring's	+	–	R	L	
☐	Codman's	+	–	R	L	
☐	Dawbarn's	+	–	R	L	
☐	Dugas	+	–	R	L	
☐	Impingement	+	–	R	L	
☐	Gait	WNL		Abn.		

11. Posture

Area	Findings
F H P	+ –
Head Tilt	R L
Head Rot.	R L
↑ Shoulder	R L
Thor. Tilt	R L
Thor. Trans.	R L
↑ Hip	R L
Hip Rot.	R L
Foot Flare	R L

12. Asymmetry/Misalignment/ Subluxations

Diagnosis

1-

2-

3-

4-

5

Notes:

Examiner/Doctor Signature Date

JDD, DC 5/2011

NEW PATIENT INTAKE

Name: _____ Today's Date: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

We use text messaging for appointment reminders. Who is your cell phone company? _____

Email Address: _____ Male _____ Female _____

Social Security # _____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address: _____

Single _____ Married _____ Spouse's Name _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office ? _____

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____

Guardian Signature _____ Date_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date

Family Health History

Patient Name: _____ Date: _____

Directions: Please review the listed symptoms and conditions. Indicate those that are *current* health problems of a family member by writing "C" in his/her column. Indicate those that are *past* health problems of a family member by writing "P" in his/her column. Leave blank those spaces which do not apply. Indicate *deceased* family members with a "D" and the age of death (if known) on the age line.

Condition	**Father** Age:	**Mother** Age:	**Spouse** Age:	**Sibling 1** Age:	**Sibling 2** Age:	**Child 1** Age:	**Child 2** Age:	**Child 3** Age:
Allergies								
Anxiety								
Arthritis								
Back Pain								
Cancer								
Constipation								
Diabetes								
Disc Problems								
Epilepsy								
Frequent Colds/Flu								
Gas/Bloating								
Headaches								
Heartburn								
Heart trouble								
High Blood Pressure								
Low Energy								
Migraine								
Neck Pain								
Nervousness								
Pinched Nerve								
Scoliosis								
Sleep Problems								
Other:								
Other:								

Financial Policy

We may bill your insurance company as a courtesy to you. Please provide your current insurance information at your first appointment. If there are any changes in your insurance information, please alert the staff as soon as possible.

You are responsible to pay the estimated balance that your insurance will not cover. This balance is due at the time of service. We accept cash, checks, and debit/credit cards, including HAS and Care Credit.

By signing this document, you are acknowledging that you accept the following terms:

1. Payment for services rendered is due in full on the date of service.
2. Payment for equipment or supplements is due the day the order is made.
3. An interest fee will be added to all overdue balances.
4. An additional fee will be sent to all overdue balances sent to collections.
5. There is a $25 charge on all returned checks with insufficient funds.

Lifetime Insurance Authorization

Please initial all items below:

_____ I understand that De Melo Chiropractic will verify my eligibility and benefits information to the best of their ability.

_____ I understand this does not guarantee payment by my insurance company or that all information will be correct.

_____ I request that payment of authorized benefits from my insurance policy or program be made to me or, on my behalf, to De Melo Chiropractic for any products/services furnished and provided to me.

_____ I authorize any holder of medical information about me at this office to release any information needed to determine these benefits or benefits for related services.

_____ I understand that I am financially responsible for all charges, whether or not paid for by my insurance company.

_____ I understand that it is not the responsibility of De Melo Chiropractic to inform me when my insurance benefits run out, and that I will be financially responsible for all services and products not covered by my insurance company once my benefits run out.

Patient Name (Please Print): _____

Parent/Guardian Name (if patient is a minor): _____

Patient/Parent/Guardian Signature: _____

OUR OFFICE POLICIES

Welcome to De Melo Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for and the various methods we offer to facilitate payment for that care. Please read each policy carefully so that there is no misunderstanding as to what you can expect as a patient of this practice and what we expect in return. Once you have read "Our Office Policies", if you have any questions or if any of these policies are unclear to you and you would like further explanation before submitting your ***Application for Care***, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interest to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic care so that an informed decision can be made whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open setting, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about. You are encouraged to keep this document.

- **Patient Privacy** – Since the majority of patient care takes place in an open setting, it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter that you wish to discuss, please let us know and we will schedule a time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.
- **Your Care** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at ***De Melo Chiropractic*** rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Thompson Drop Technique, Activator Methods, and Palmer Diversified Chiropractic. It is important that you understand both the objective and the method(s) so that there is no confusion or disappointment. Tremendous progress has been made in the rehabilitation and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.
- **First Things First** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.
- **Patient's Report of Findings** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case. Because the results of your X-Rays and all examinations, as well as the doctor's recommendations for care, will be discussed at that time, we strongly urge new patients to invite spouses or significant others to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

OUR OFFICE POLICIES

(signature page)

I have retained pages 1 of 2 of the 'Office Policies' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's 'Office Policies', a two-page document, the first page of which I have read and retained. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name DOB

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date

OUR PATIENT PRIVACY NOTICE

De Melo Chiropractic

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of our Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your PHI, and the potential circumstances under which, by law or as dictated by our Office Policy (see accompanying documents), we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, it will be provided to you. In addition, you will find we have placed several copies in report folders labeled **HIPAA** on tables in the reception area. Once you have read this notice, please sign the last page, and return it to our front desk receptionist. You are encouraged to keep this first page for your personal records.

Permitted Disclosures:

1. Treatment Purposes – discussion with other health care providers involved in your care.
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. Payment Purposes – to obtain payment from your insurance company or any other collateral source.
4. Workers Comp. Purposes – to process a claim and/or aid in an investigation.
5. Emergency Purposes – to notify a family member in the event of a medical emergency.
6. Public Health and Safety – in order to prevent or lessen a serious or eminent threat to the health and/or safety of a person or general public.
7. Gov. Agencies/Law Enforcement – to identify and/or locate a suspect, fugitive, material witness or missing person.
8. Benefit Purposes – for military and national security members, prisoners, and government workers.
9. Deceased Persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Notifications – we may call, text or email your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of Ownership – in the event that this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the Patient Privacy Notice.
3. To request mailings to an address other than your residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, and to request amendments to information, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction is provided.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-Rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will happily accommodate you. However, you will be responsible for costs.
7. To file a formal complaint about how we handle your health information.

Complaints: If you wish to make a formal complaint about how we handle your health information, you can request the doctor's contact info at the front desk. If either is unavailable, you may make an appointment with our receptionist to see them within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

OUR PATIENT PRIVACY NOTICE

(signature page)

I have retained pages 1 of 2 of the 'Patient Privacy Notice' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's Patient Privacy Notice, the first page of which I have read and retained for my personal records. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice' I understand my rights, as well as this practice's duty to protect my PHI, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Patient Privacy Notice' at any time in the future and will make the new provisions effective for all information that it maintains, past and present.

I am aware that a more comprehensive version of this Notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprains/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one instance per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments, and all other procedures provided at ***De Melo Chiropractic*** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent treatment by any means, method, and/or techniques that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____

Patient or Authorized Person's Signature Date Witness Initials

Regarding: X-Rays/Imaging Studies – *Females Only*

Please read carefully and check the boxes. Please include the appropriate date, then sign below if you understand and have no further questions. Otherwise, please see our receptionist for further explanation.

☐ The first date of my last menstrual cycle was on ____/____/ ____.

☐ I have been provided a full explanation of when I am most likely to become pregnant and, to the best of my knowledge, I am not currently pregnant.

By my signature below, I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child. I have conveyed my understanding of the risks associated with exposure to X-Rays. After careful consideration, I therefore do hereby consent to have the diagnostic X-Ray examination that the doctor deemed necessary in my case.

_____ ____/____/____ _____

Female Patient or Authorized Person's Signature Date Witness Initials