Boyd Chiropractic Inc.

NAME: _____ **DATE:** _____ **REFERRED BY:** _____

ADDRESS: _____ **APT#** _____

CITY _____ **STATE:** _____ **ZIP** _____

EMAIL ADDRESS: _____ optional **CURRENT AGE:** _____

HOME PHONE# : ( ) _____ **CELL PHONE # : ( )** _____

DATE OF BIRTH: _____ **GENDER M F** **MARITAL STATUS S M D W # of CHILDREN:___**

OCCUPATION : _____ **EMPLOYER:** _____

SPOUSE NAME: _____ **SPOUSE OCCUPATION:** _____

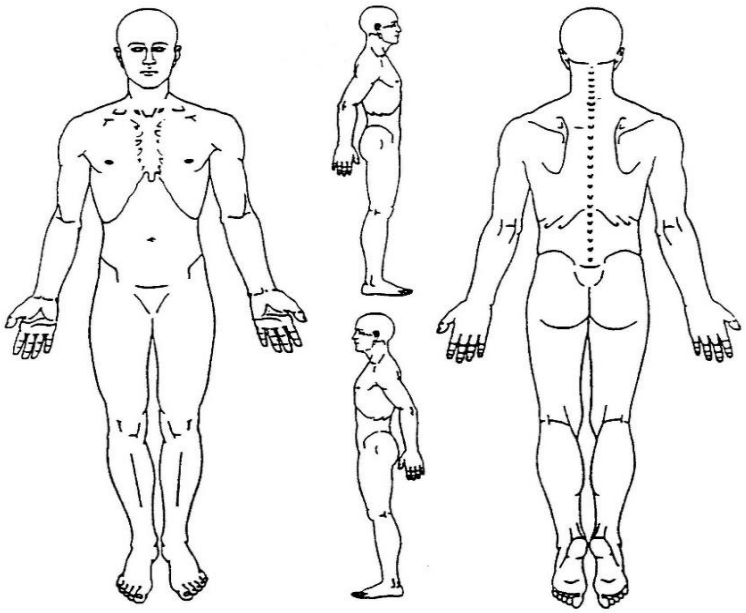
******** If patient is a Minor, Please provide Parent information********

Parent Name: ***HOME# CELL#***

Do you ever suffer from:			
Dizziness	Yes / No	Pinched Nerve	Yes / No
Backaches	Yes / No	Digestion Problems	Yes / No
Heart Trouble	Yes / No	Nervousness	Yes / No
Diabetes	Yes / No	Sinus Trouble	Yes / No
Anemia	Yes / No	High Blood Pressure	Yes / No
Arthritis	Yes / No	Cancer	Yes / No
Headaches	Yes / No	Chest Pains	Yes / No
Asthma	Yes / No	HIV/Aids	Yes / No

Surgeries		**Past Treatment/Therapy**	
Neck	Yes / No	Yes / No	
Back	Yes / No	Yes / No	
Hips	Yes / No	Yes / No	
Knees	Yes / No	Yes / No	
Ankles	Yes / No	Yes / No	
Shoulders	Yes / No	Yes / No	
Elbows	Yes / No	Yes / No	
Wrists	Yes / No	Yes / No	

Please circle where it hurts today



Chief Complaint :

When did it start hurting? _____

What caused the pain? _____

Have you been to a Chiropractor Before? Y /N

Name:

Last Visit:

Are you? [ ] Military Service [ ] Police / Fire Service [ ] First Responder Services

If your injury was accidental, please complete the following questions:

Date of Accident: _____ Time: _____ Location _____

How did the accident occur? On the Job _____ Automobile Accident: _____ Other _____

Do you have an attorney advising you in this case Yes / No Has a report been filed? Yes / No

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

Chiropractic I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy by Joe Tate D.C..

[ ] Patient Name _____

PARENT Name: If Patient is a Minor. _____

I will have an opportunity to discuss with Dr. Joe Tate, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, and in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, dislocation of joints and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication. I wish to rely upon the doctor for recommendation during the course of the treatment, based upon the facts that are known to him, for my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its 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 my present condition and for any future condition(s) for which I seek treatment.

( ) Patient/ Responsible Party's Signature _____ Date _____

********** **********

Softwave Only

Suitability for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies.

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have Cancer / Tumor Yes / No
- Do You have a skin infection? Yes / No
- Are you pregnant or do you suspect your may be pregnant Yes / No
- Are you under the age of 16 years of age? Yes / No

Risk of the Procedure

a) Pain and soreness. This is temporary and resolves after a few days.

b) The FDA has labeled this a Non-Significant Risk therapy

Consent for Procedure

I, _____, The Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of _____.

I have been fully informed of ESWT which the use of has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already provided or offered to me.

( ) Signed: _____ Date:_____

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Phone # 940-433-2710

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