

Egan Family Chiropractic

Helping Families Since 1996

EganChiropractic.com

What is Chiropractic Care?

The purpose of Chiropractic is to restore and maintain the proper relationship between the spine and nerve system. Nerve pathways that are vital to live are housed in and protected by the bones of the spine. Small misalignments of the vertebrae (bones of the spine) which interfere with the function of these nerve pathways are called **subluxations**. Subluxations come from many causes (physical, chemical, and mental stresses) and prevent various organs, glands, and tissues in the body from functioning properly. Subluxations can be found in both children and adults and when present are equally damaging to both.

By means of a Chiropractic adjustment, subluxations are reduced/corrected and normal nerve function is then restored. The goal of chiropractic is simply this: To adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve energy over the nerve pathways so every part of your body can function with a normal nerve supply at all times.

This allows the innate (inborn, natural) ability of the body to work at maximum efficiency, allowing you to express your innate potential for health to the best of your body's ability.

Regardless of what the disease is called, the Chiropractor DOES NOT offer to heal or even treat disease; nor does he offer the advice regarding the treatment of disease; the only goal of Chiropractor is to allow the body to do its job. The only means is by an adjustment of the vertebral subluxation. The Chiropractor's goal is to remove nerve system interference and allow the body to heal naturally and reach its maximum potential for health.

Webster's Dictionary defines health as: "A condition of wholeness in which all of the organs are FUNCTIONING 100% all the time."

Gray's Anatomy states: "The purpose of the brain and nerve system is to control and coordinate the FUNCTION of all the tissues, organs and systems of the body and to adapt the organisms to its environment."

Millions of people around the world have made Chiropractic care a regular part of their lives. Take responsibility for your own life and health! See your family Chiropractor today. Thinking globally, acting locally, and changing the world one spine at a time.

Discover Chiropractic!

Health History

Name _____ Date _____

Address _____ City/State/Zip _____

Home Phone _____ Cell _____

Occupation _____ Work Phone _____

Birthdate _____ Age _____ Spouse _____

Social Security # _____ e-mail _____

Who Referred you to us? _____

Reason for Consulting this office? _____

When did this start? _____

Has this ever happened before? _____ When? _____

Is it: Getting better? _____ Staying the same? _____ Getting worse? _____

What does this condition keep you from doing? _____

How long has it been since you have felt good? _____

Past Chiropractic Care? Yes/No

Dr.'s Name and Location _____ Last Visit _____

Current Medical Care? Yes/No Why? _____

Current Medication _____

What is your current goal for HEALTH/WELLBEING: Relief of a symptom or optimum health and well being?

Have you ever been in an auto accident? Yes/NO When? _____

Is this visit in regards to a Personal Injury or Workmen's Comp? Yes/No

We accept payment by cash, check, and credit card. I understand that all services are to be paid in full at the time of services, unless other arrangements have been made and agreed upon in writing. If collection is necessary there will be an 18% annual interest rate added to the total due and the patient will also be responsible for any fees in the collections process allowable by law.

Signature

Date

Name _____ Date _____

Have you suffered from the following in the last 6 months?

- headaches asthma sciatica PMS nervousness allergies low back pain
- irregular cycle sore throats chronic colds numbness in legs excessive flow fibromyalgia
- sinus troubles hemorrhoids hot flashes poor circulation ear infections carpal tunnel
- painful periods neck stiffness/pain thyroid problems arm pain growing pains chronic fatigue
- impotency arm numbness liver problems mental illness hip pain upper arm pain
- digestive issues insomnia inverted foot shoulder pain bed wetting dizziness knee pain
- elbow pain bladder pain chronic cough rapid heart rate wrist pain constipation

Please describe your job _____

What does your job require: lifting pulling pushing twisting bending computer use
 typing answering phones

Exercise: none moderate daily

Hobbies: Sports _____ Home activities _____

Outdoor Activities _____ Other _____

Do you have any problems with your feet? Yes/No

To be completed by ALL WOMEN of Child Bearing Age (13-49) BEFORE X-RAYS CAN BE TAKEN

Last Menstrual Date _____ Do you use contraceptives _____

Is there any possibility that you are pregnant at this time? _____

Signature _____

Date _____

Family History- Please describe if any family member (father, mother, sister, brother, or child) has any of the following:

- | | | | | |
|------------------|----------------|---------------|---------------------|----------------|
| cancer | diabetes | heart trouble | high blood pressure | mental illness |
| stroke | kidney disease | anemia | headaches | osteoporosis |
| arthritis | joint problems | scoliosis | back problems | disc problems |
| genetic diseases | | other | | |

Terms of Acceptance-

It is clearly understood that there is no promise or offer of any kind, on the part of the doctor or this office, to treat any symptom, condition, or disease. Although I may come to this with initial expectation of relief of a particular symptom or condition, it has been clearly explained to me that the only purpose of chiropractic care is to remove a subluxation (misalignment of the bones of the spine. This correction is undertaken for no other reason than that these vertebral subluxations interfere with the capacity of the body to fully express itself. _____

Signature

Date

Privacy Rights- Egan Family Chiropractic follows the HIPPA Privacy Act. This act is to ensure the clients appointment times, care that is received, and all records are not shared with any individual or organization without written authorization. A copy of your privacy rights can be obtained at the front desk upon request. _____

Signature

Date

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Informed Consent

You have the right to be informed about your condition and the possible treatment options. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care.

When a patient seeks chiropractic care it is important for the doctor and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change the nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment is a specific thrust into the misaligned joint that helps restore normal motion. This allows the nervous system to work better at keeping you healthy.

In addition to the many benefits of chiropractic care, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel starting care include muscle spasm, nausea, dizziness, and soreness. These should subside after your first 3-5 visits. Severe risks such as nerve injury, fracture, and stroke are very rare but can occur. The technique used in this office is very gentle and greatly decreases these risks. There is no guarantee that the treatment will provide the expected or desired outcomes. Your lifestyle, including diet, exercise and stress level, will affect your results.

If, at any time, you have questions or concerns regarding your treatment please call our office. The doctor will be happy to discuss them with you.

I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed.

Print

Date

Signature