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| --- | --- |
|  | Hattersley Chiropractic  10430 Park Rd Ste 100B  Charlotte, NC 28210  (704) 614-6184 |

**CONFIDENTIAL PATIENT INFORMATION**

**Personal Information**

|  |  |
| --- | --- |
| **Full name: Date:** | |
| **Address:**  Street City State Zip | |
| **Home phone:** | **Work phone:** |
| **Cell phone:** | **Email address:** |
| **Best time/place to contact you:** | |
| **Date of birth:** | **Age:** |
| **No. of children:** | **Pregnant? Yes** □ **No** □ |
| **Height:** | **Weight:** |
| **Driver’s license number:** | |
| **Marital status: M S W D** | **Spouse/guardian name:** |
| **Occupation:** | |
| **Employer’s name & address:** | |
| **Name of person responsible for account:** | |

**Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Addressing What Brought You Into This Office:**

*If you have no symptoms or complaints and are here for Wellness Services, please skip to the* ***“General Health History”****.*

**Health Concerns**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please list your health concerns according to their severity | Rate of severity  1 = mild  10 = worst imaginable | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | % of the time pain is present |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What have you done for this condition? Was it of benefit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I do (do not) have a family history of this or similar symptoms (Please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Which activities aggravate your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What makes it better or worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other doctors you have seen for this condition:

|  |  |
| --- | --- |
| Chiropractor | □ |
| Physical Therapist | □ |
| Medical Doctor | □ |
| Other (please describe) | □ |

Doctor’s details:

|  |  |  |
| --- | --- | --- |
| Name: | |  |
| When did you see them? | | |
| What did they say was wrong? | | |
| Did it help? | What did they do? | |

|  |  |  |
| --- | --- | --- |
| Name: | |  |
| When did you see them? | | |
| What did they say was wrong? | | |
| Did it help? | What did they do? | |

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc?

(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is this condition interfering with any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Work □ | Sleep □ | Daily routine □ | Sports/exercise □ | Other □ (please explain): |

**General Health History**

*Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

Have you had any surgery? (Please include all surgery)

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Doctor |
| 2. Type: | When? | Doctor |
| 3. Type: | When? | Doctor |
| 4. Type: | When? | Doctor |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Hospitalized? Yes □ No □ |
| 2. Type: | When? | Hospitalized? Yes □ No □ |
| 3. Type: | When? | Hospitalized? Yes □ No □ |

Have you ever had x-rays taken?

|  |  |  |
| --- | --- | --- |
| Area of body: | When? | Where? |

Do you wear orthotics or heel lifts? Yes □ No □

**Current Medicines and Supplements**

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diet**

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

**D** - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week

**FM** - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol | Eggs | Fasting | Artificial Sweetener |
| Tobacco | Fruit | Diet food | Weight Control Diet |
| Coffee | Beef | Refined Sugar | Raw Vegetables |
| Soda | Poultry | Fish | Whole Grains |
| Fried Foods | Organic foods | Seafood | Dairy |
| Cooked or canned vegetables | | | |

The type of diet I usually follow is classified as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health History**  
Please mark the following conditions you may have had or have now (- have had + have now):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ Alcoholism | □ Allergy | □ Anemia | □ Arteriosclerosis | □ Arthritis | □ Asthma |
| □ Back Pain | □ Cancer | □ Cold Sores | □ Constipation | □ Chron’s disease | □ Depression |
| □ Diabetes | □ Diarrhea | □ Eczema | □ Emphysema | □ Epilepsy | □ Gall Bladder Problems |
| □ Gout | □ Headaches | □ Heart Attack | □ Heart Disease | □ High Blood Pressure | □ Anxiety |
| □ Irregular Periods | □ Low Blood Sugar | □ Lyme’s | □ Strep throat | □ Menstrual Cramps | □ Migraines |
| □ Miscarriage | □Multiple Sclerosis | □ Food sensitivities | □ Neck Pain | □ Nervousness | □ Neuritis |
| □ Pleurisy | □ Pneumonia | □ Irritable bowel syndrome | □ Fibromyalgia | □ Ringing in ears | □Sinus Problems |
| □ Stroke | □ Thyroid Problems | □Tuberculosis | □ Ulcers | □ Problems sleeping | □ Acid reflux |

Other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Stressors**

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, sports etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don’t drink enough water, drugs/alcohol, etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

|  |  |  |
| --- | --- | --- |
| At work: | At home: | At play: |

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Eating habits: | Exercise habits: | Sleep: | General health: | Mind set: |

How do you grade your physical health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

How do you grade your emotional/mental health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

Is there anything else which may help to better understand you which has not been discussed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you here at this point in time? What can we do that may help to improve your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I consent to a professional and complete examination and to any additional tests that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_