WELCOME

PERSONAL INJURY

Chart #:__

Patient Information

Name: _____
Last First MI

Mailing Address: _____

Phone# (H)_____ (M) _____

Date of Birth: _____ Sex: ☐ Male ☐ Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Employer:_____ Phone:_____

May we call you at work? ☐ Yes ☐ No Can we leave a voicemail/message? ☐ Yes ☐ No

Who referred you to our practice? _____ ☐ Insurance Book ☐ Yellow Pages

Emergency contact: Name:_____ Relation:_____

Phone: (H)_____ (W)_____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other_____

Has it been reported? ☐ Yes ☐ No If yes to whom?_____

Financial Information

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier:_____

Name of person whose is the policy holder of this insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ Group #_____member services phone number _____

We cannot file your insurance if this section is left uncompleted and the bill will be sent to you.
PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

HIPAA

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ DATE_____

IF THIS IS A PERSONAL INJURY SITUATION PLEASE BRING:

1. COPY OF ACCIDENT REPORT
2. COPY OF AUTO INSURANCE CARD

Form 3

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Arm/Hand Pain
- ☐ Leg/Knee Pain
- ☐ Headaches
- ☐ Dizziness
- ☐ Asthma
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Fatigue
- ☐ Sleeping Difficulties
- ☐ Loss of Smell
- ☐ Allergies
- ☐ Blurred Vision
- ☐ Light Bothers Eyes
- ☐ Depression
- ☐ Nervousness
- ☐ Tension
- ☐ Cold Sweats
- ☐ Stomach Problems
- ☐ Night Pain
- ☐ Sudden Weight Loss
- ☐ Loss of Taste
- ☐ Loss of Memory
- ☐ Jaw Problems
- ☐ Constipation
- ☐ Shortness of Breath
- ☐ Bowel/Bladder Changes
- ☐ Nausea
- ☐ Cold Feet
- ☐ Chest Pain
- ☐ Fever
- ☐ Fainting

Please check to indicate if you have ever had any of the following:

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Other _____
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain_____

Please list any medications you are currently taking:_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):_____

_____

_____

Please list any allergies:_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

☐ Heart Disease_____ ☐ Diabetes_____

☐ Cancer_____ ☐ Arthritis_____ ☐ Other_____

Do you exercise? ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following?

Caffeine_____ cups/day Alcohol_____ drinks/week Cigarettes_____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT SIGNATURE (X)_____ DATE_____

PARENT/GUARDIAN SIGNATURE (X)_____ DATE_____

CHART #_____

Current Symptom(s)

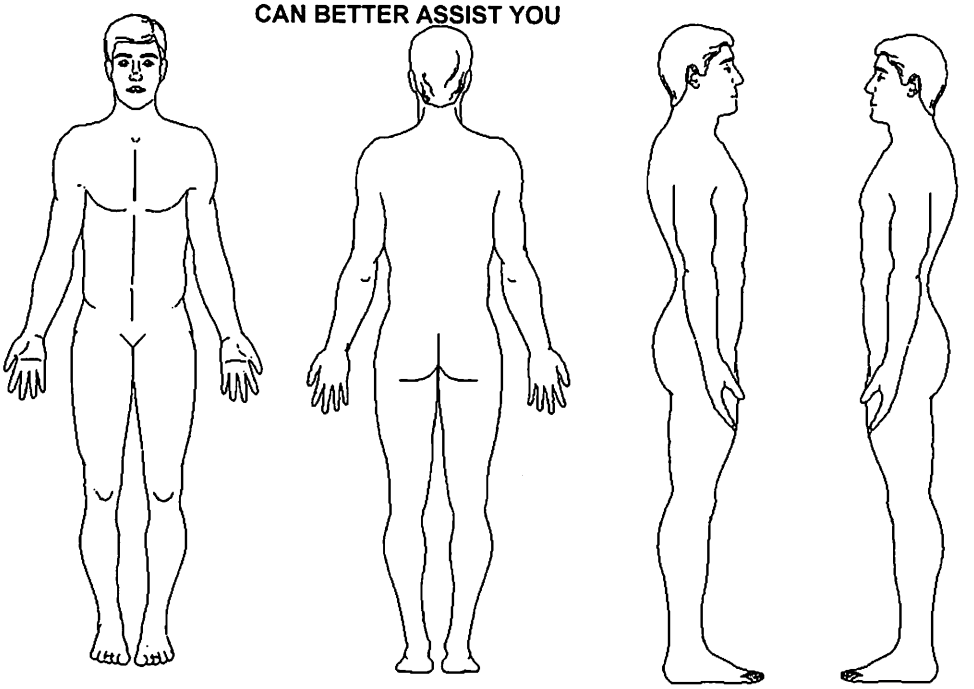
NAME: _____ Chart #: _____

Reason for visit_____

_____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING. PLEASE MARK ALL SYMPTOMS THOUROUGHLY SO WE CAN BETTER ASSIST YOU**

KEY:
P = Pain
D = Dull
N = Numb
B = Burning
T = Tingling
SH= Shooting
TH= Throbbing
O = Other
M = Muscle Spasm



* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**

(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____ at it's worst

When did you first notice the symptoms?_____

Did anything cause the pain/symptoms?_____

Is the pain: ☐ Constant OR ☐ intermittent (Come and Go)

Is it getting progressively worse? ☐ No ☐ Yes

Type of Pain? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling ☐ Other

Does anything make it worse?_____

Does anything make it better?_____

Does it radiate? ☐ No ☐ Yes ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day?_____

Do you experience night pain? ☐ No ☐ Yes, explain_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done to treat the pain before today?_____

PATIENT SIGNATURE (X)_____DATE_____

PARENT/GUARDIAN SIGNATURE (X)_____DATE_____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment: _____

MEDICAL RECORDS REQUEST

DATE:_____

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To:_____ (primary care physician)

_____ (significant other)

_____ (attorney/case manager)

_____ (other care takers)

I, _____ hereby request that my recent medical records be released to:

_____ Physician of _____ practice.

Your Clinic Name and Address Here

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME:_____

PATIENT ADDRESS:_____

PATIENT'S DATE OF BIRTH:_____

PATIENT/GUARDIAN SIGNATURE:_____

Motor Vehicle History Form

Name _____ Date of MVC _____ Today's Date _____

Patient was: Driver _____ Passenger: Front _____ Back _____ Other _____

Vehicle (Year/Make/Model) _____
Other Vehicle (Year/Make Model) _____

Time of Accident: _____ Day _____ Night _____ Dawn _____

Stopped _____ Moving _____ Estimated Speed MPH _____

Road Condition: Dry _____ Damp _____ Wet _____
Headrest: None _____ Integral _____ Adjusted in _____ Position
Seatbelt: None _____ Not Wearing _____ Wearing _____
Shoulder Harness: None ____ Not Wearing _____ Wearing ___ Wearing Under Arm _____

Head Position: Ahead ____ Right ____ Left ____ Looking : Down ____ Up ____ Straight ____

Hands: One hand on wheel ____ Both hands on wheel ____ In Lap ____ Other ____

Brakes on: Yes ____ No ____ Other ____

Transmission: Manual ____ Automatic ____

Description of Accident:

_____
_____
_____
_____

Aware of impending collision: Yes ____ No ____ Did air bags deploy: Yes ____ No ____

Body position at time of impact: Sit straight in seat _____ Other _____

Felt body go: Forward then back _____ Back then forward _____ Side to side _____
Second collision in vehicle: None _____ Yes _____
Second collision outside vehicle: None _____ Yes _____

Wearing glasses: Yes _____ No _____ Still on Yes _____ No _____
Wearing hat: Yes _____ No _____ Still on Yes _____ No _____

Loss of consciousness: Yes _____ Length of time _____ No _____

Estimated property damage: _____ Totaled ____ Drivable _____ Not drivable ____ Seat _____

Others in car: Yes _____ # of injured _____ No _____

Police on scene: Yes_____ No _____ Report made: Yes _____ No _____

Symptoms: Initial _____ or length of time after accident _____: None _____
Headache _____ Dizzy _____ Disoriented _____ Shock _____ Neck pain/Stiffness _____
Low Back Pain/Stiffness _____ Numbness/parenthesis area _____ Other _____

AFTER MVC:

Went Home _____ Went to Work _____

Went to Medical Doctor _____ Date: _____ DR. Name: _____

Doctors' Recommendation: _____

Went to _____ Hospital later (date/time) _____

Taken by _____ to _____ Hospital

Back brace _____ Collar _____ Backboard _____ Other _____

TREATMENT AT HOSPITAL:

X-Ray _____ CT Scan _____ Lab Work _____

Collar _____ None _____ Other _____

Diagnosis _____

Prescriptions _____ YES _____ NO
Name _____ Filled _____ Taking _____
Name _____ Filled _____ Taking _____
Name _____ Filled _____ Taking _____

FOLLOW UP INSTRUCTIONS:

1. Home Care Instructions: _____ Ice _____ Heat
2. Follow – Up with Medical Doctor _____ YES _____ NO

Doctor Recommendation: _____

_____

3. Work Restrictions: _____

_____

Revised 9/7/06

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

WATKINS
TOTAL
HEALTHCARE

961 Green Street, NE, Gainesville, GA 30501
770-534-0656 – Phone
770-534-9553 – Fax

PATIENT & ATTORNEY CONTRACT AGREEMENT

Date: _____

PATIENT/CLIENT NAME: _____

_____ is representing me in the collection of
ATTORNEY NAME

damages for personal injuries received by me as the result of a Motor Vehicle Accident. The

MVA occurred on _____.

I understand that payment is to come out of any settlement or collections. I further understand that I am personally and fully responsible for the sum total of my charges if no settlement is reached.

I also am directing and authorizing my attorney that all unpaid charges incurred by me as a result of the accident are to come out of any settlement or collections.

I am advised the final payment shall include but not limited to treatment, examination, re-examination, counseling, billing, reproduction of records, massage, therapy, notes, supplies and narratives. Once there is a final settlement it will be paid directly to Watkins Total Healthcare by the attorney. If the attorney does not issue payment, I then understand the outstanding bill for services rendered is my responsibility and I agree to pay Watkins Total Healthcare in full.

_____ / _____ / _____

Patient or Guardian Signature PRINT NAME Date

ATTORNEY

I, _____ the attorney representing the above said client hereby acknowledges receipt of the foregoing letter. I agree to pay Watkins Total Healthcare out of the proceeds of such settlement or collection as per my client's direction stated above.

_____ / _____

Attorney At Law SIGNATURE Date

WATKINS
TOTAL
HEALTHCARE

AUTHORIZATION TO SIGN

PATIENT & ATTORNEY CONTRACT AGREEMENT

I, _____, the undersigned, do hereby authorize and direct my attorney to enter into an agreement with Watkins Total Healthcare, my health care provider to ensure the payment of my medical bills to said healthcare provider form my portion of any settlement or verdict proceeds.

I further certify that I understand this authorization gives my attorney express authority to deduct medical expenses from my portion of any recovery in my case. I instruct my attorney(s) to deduct sufficient monies to pay the outstanding medical bills due Watkins Total Healthcare and pay the sum of the medical lien to Watkins Total Healthcare without further written authority from me.

My attorney(s) and the undersigned healthcare provider, Watkins Total Healthcare have explained to me that signing this Contract/Lien to the extent necessary to cover the medical expenses is irrevocable; that is, I man not cancel or withdraw such consent to pay Watkins Total Healthcare without Watkins Total Healthcare's written notarized authorization for me to cancel the Contract/Lien.

Jeanne L. Hanlin, **Director of Operations, Watkins Total Healthcare**
Healthcare Provider – Authorized Signature

DATE: _____ **Name of Client:** _____

Witness: _____

WATKINS
TOTAL
HEALTHCARE

Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic exercise, neuromuscular massage, or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: **The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet.** The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, or organization other than myself.

_____
Patient PRINTED NAME

_____
Patient Signature Date

_____ _____
Witness PRINTED NAME Witness Signature Date

961 Green Street NE, Gainesville, GA 30506, Phone 770-534-0656, FAX 770-534-9553