



Partners In Chiropractic
TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read fully and understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Print

Sign

Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Jumper has my permission to perform an X-Ray evaluation. I have been advised that X-Rays can be hazardous to an unborn child. Date of last menstrual period: _____.

PATIENT HISTORY

Date: _____
Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____ H/Cell Phone: _____
Birthdate: _____ Sex: _____ Age: _____ Marital Status: _____ #of Children: _____
Occupation: _____ Employer: _____ Work Phone: _____
Social Security Number: _____ Driver's License #: _____
Email: _____ Spouse / Significant Other: _____
Emergency Contact Name & Phone: _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

MAJOR COMPLAINT: _____

How long have you had this condition: _____

Date began: _____

Have you lost work days: Yes () No () How many: _____

Have you had this similar condition before? Yes () No () When? _____

Was the injury related to: Work () Automobile () Other () _____

Have you seen a Chiropractor in the past: Yes () No () If yes, when: _____ Dr.: _____

Why did you see this Chiropractor: _____ Were you helped: _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine: _____

Did you follow it: _____ If not, why: _____

Why are you changing Chiropractors: _____

BLOOD PRESSURE: _____

PULSE: _____

HEIGHT: _____

WEIGHT: _____

PAST (O) PRESENT (X) CONDITIONS:

- | | | |
|---|---|--|
| <p>A</p> <ul style="list-style-type: none">___ Fractured Bones___ Auto Accident(s)<ul style="list-style-type: none">(a) ___ 0-1 year ago(b) ___ 1-5 years ago(c) ___ more than 5 years ago___ Other Accidents / Falls___ Knocked Unconscious___ Back Curvature___ Mental or Emotional Disorders___ Arthritis___ Diabetes___ Swollen or Painful Joints___ Convulsions / Epilepsy___ Skin Problems___ Itching___ Bruise Easily___ Cancer___ Frequent Colds / Flu <p>B</p> <ul style="list-style-type: none">___ Nervous___ Tension___ Depressed___ Irritable___ Anemia___ Excess Sweating___ Tremors___ Light Sensitive (Eyes)___ Allergy___ Sinus Problems___ Light Headed Upon Rising___ Under Stress___ Crave Sweets or Salts___ Eating Disorders <p>C</p> <ul style="list-style-type: none">___ Trouble Sleeping___ Trouble Concentrating___ Loss of Memory | <p>D</p> <ul style="list-style-type: none">___ Learning Disability___ Mistake Sidedness (R from L)___ Stutter___ Dyslexia___ Mood Changes___ Lose Temper Easily___ Headache___ Neck Pain or Stiff R L___ Numbness, Tingling, or Pain in Arms, Hands or Fingers R L___ Jaw Pain or Click (TMJ) R L___ Head Seems Heavy___ Head & Shoulders Tired___ Difficulty in Excessive Standing, Walking, Sitting, Riding, Bending, Lifting, Twisting___ Shoulder Pain R L___ Dizziness___ Ringing in Ears R L___ Hearing Loss R L___ Fainting___ Loss of Balance___ Blurred or Double Vision R L___ Upper Back Pain or Stiffness R L___ Mid Back Pain or Stiffness R L___ Lower Back Pain or Stiffness R L___ Numbness, Tingling or Pain in Buttocks, Thighs, Legs Feet R L___ Pain with Cough, Sneeze, or Strain at Stools___ Hip Pain R L___ Foot Trouble R L <p>E</p> <ul style="list-style-type: none">___ Chest Pain___ Asthma___ Lung Problems___ Difficult Breathing | <p>F</p> <ul style="list-style-type: none">___ Wheezing___ Heart Problems___ Stroke___ High or Low BP___ Varicose Veins___ Liver Trouble___ Gall Bladder Trouble___ Digestive Problems___ Excessive Gas___ Belching / Bloating After Meals___ Heartburn___ Ulcers___ Diarrhea / Constipation___ Colon Trouble___ Hemorrhoids___ Prostate Problems___ Impotence___ Kidney Trouble___ Kidney Stones___ Frequent Urination___ Discharge___ Menstrual Problems/PMS___ Menopausal Problems___ Breast Lumps, Soreness, Discharge___ Pregnant (Now)___ Bedwetting___ Ear Infections___ Hepatitis___ Venereal Disease___ AIDS / HIV <p>_____ _____ _____ _____</p> |
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WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?) _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

- _____ Temporary Relief (Help the symptom but do not fix the cause of the problem.)
_____ Maximum Correction (Correct the cause of the problem for maximum stability.)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

1. What are your favorite hobbies or activities to do now? _____
2. Are your current problems affecting these activities or hobbies? _____
3. What activities are you looking forward to doing in retirement? _____
4. Who would you like to be doing these with? _____

On a scale of 1-10 (10 being the most, 1 being the least),
_____ How committed are you to being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____

List drugs (prescription and non-prescription) / supplements you are currently taking: _____

Name other doctors you have seen for this condition, what was done and for how long: _____

Are you currently wearing: Heel Lifts () Arch Supports ()

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount or any other balance not paid for by your insurance company.

Interest charges may be applied to your unpaid balance at a rate of 18% per annum. We have a right to demand immediate payment of your full account balance if you default, subject to our giving you any notice required by law. If you are in default and fail to pay any amount you owe, you will also be liable for our collection expenses. This includes charges for reasonable attorney fees, court costs, costs of collection, and any additional fee that may be directed by the court.

I HEREBY DECLARE THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

PATIENT SIGNATURE: _____ **DATE:** _____



Partners In Chiropractic
X-Ray Consent Form

The doctor has explained that the purpose of the X-Rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness for chiropractic adjustments. If the doctor discovers a non-chiropractic “unusual finding” when reviewing this X-Ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal X-Rays.

Signature: _____ Date: _____



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INFORMED CONSENT AND PERMISSION FORM

When you give permission to have chiropractic spinal adjustments and physical medicine modalities performed, you or your guardian should understand the most common risks and hazards of the procedures. The following are all rather infrequent but any may occur.

1. Post-treatment discomfort, soreness or stiffness, which may persist 12-24 hours after treatment.
2. Transient lightheadedness or dizziness following chiropractic adjustments of the neck. Please alert Dr. Jumper should this reaction occur.
3. Aggravation of acute intervertebral disc bulge or herniation. Please be advised that Dr. Jumper will make every reasonable effort to determine the possibility of an underlying disc problem and modify your treatment recommendations accordingly.
4. Spontaneous vertebral body or rib fracture in an osteoporosis patient. Please be advised that Dr. Jumper will make every reasonable effort to diagnose this preexisting condition and modify your treatment recommendations accordingly.
5. Acute muscle spasm alongside the spine in the area being treated or in an adjacent area. These muscle spasm reactions are commonly present, even before treatment, in the acute patient and every effort will be made to reduce them prior to spinal adjustments.

I understand that no guarantee has been made that the procedures used will cure my condition.

Patient / Guardian Signature _____ Date _____

Printed Name _____