Ohana Chiropractic

1122 Logan Avenue Cheyenne, WY 82001

Patient Demographic Form

Please PRINT

Patient Name: _____ Nickname/AKA: _____

Date of Birth: _____ Social Security Number: _____Sex: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Would you like appointment text reminders? Yes No

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Widower

Language (other than English) : _____ Race: _____ Ethnicity: _____

Email address: _____ Employer: _____

Spouse/Parent: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us: □ Internet □ Prior Office Patient □ Existing Patient _____

□ Other Physician _____ □ Marketing Event _____

Military / Veteran / First Responder □ Yes □ No

Are you covered as a family member under our Discount Medical Plan? □ Yes □ No

Acupuncture Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, massage, heat therapy, ear seeds, dietary advice, and lifestyle counseling. I understand that these therapies are safe methods of treatment. As with all medical procedures, they involve potential but unlikely risks. Such uncommon risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible but highly unlikely (we have never witnessed this), as the clinic uses alcohol, sterile disposable needles, and a safe and clean environment. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of acupuncture treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs. Acupuncture is a natural medicine that works with the body's ability to heal itself but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Regular treatment and completing the prescribed treatment plan are what gives acupuncture the best results. I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant. I understand that nutritional supplements recommended to me by by my acupuncturist are safe in the recommended doses. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his/her judgement in my best interest during the course of treatment, based upon the facts then known. In signing this form, I acknowledge any inherent risks and complications of treatment, payment and healthcare procedures received, incurred, or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions, and medications, and I will keep her updated on any changes.

Patient Signature Date

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Our disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date last menstrual cycle: _____

_____

Signature Date