***Whom may we thank for referring you to this office 🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?***

**APPLICATION FOR CARE AT ABSOLUTE HEALTH SOLUTIONS, INC.**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **❑** Single **❑** Married Do you have Insurance: **❑** Yes **❑** No Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**

**Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? 🞏 AM 🞏 PM 🞏 mid-day 🞏 late PM

How long does it last? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes throughout the week

**How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_**

**C**ondition(s) ever been treated by anyone in the past? 🞏No 🞏 Yes **If yes,** when: \_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏 N/A**

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S =** **S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL USUAL ACTIVITY LEVEL**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your problem the result of ANY type of accident? 🞏 Yes, 🞏 No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? \_\_\_\_\_\_\_\_ \_ When was the last episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_

Other forms of treatment tried: 🞏 No 🞏 Yes **If yes,** please state **what** type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whoprovided it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long ago? \_\_\_\_\_\_\_**What were the results. 🞏 Favorable 🞏 Unfavorable🡪 please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** haveand **N** for *N****ever*** *have had***:**

\_**\_\_** Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis \_\_\_Fracture **\_\_\_**Disability \_\_\_Cancer

\_\_\_ Heart Attack \_\_\_Osteo Arthritis \_\_\_Diabetes **\_\_\_**Cerebral Vascular **\_\_\_** Other serious conditions:

 **PLEASE identify** **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

|  |
| --- |
|  **HOW LONG AGO TYPE OF CARE RECEIVED BY WHOM**  |
| **INJURIES 🡪**  |
| **SURGERIES 🡪** |
| **CHILDHOOD DISEASES🡪**  |
| **ADULT DISEASES 🡪**  |

**SOCIAL HISTORY**

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes 🡪 How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. Alcoholic** **Beverage**: consumption occurs 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**3. Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**4. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following, See pg 2- Activities of Life

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

 **If yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister’s ❑ brother’s ❑ son(s) ❑ daughter(s)

 Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don’t know

**2. Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment to be made directly to ABSOLUTE HEALTH SOLUTIONS, INC. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient or Authorized Person’s Signature Date Completed**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

 **Doctor’s Signature Date Form Reviewed**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**\_\_/\_\_\_/\_\_\_

 **Activities of Daily Living/Symptoms/Medications**

 **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ File#\_\_\_\_\_\_\_\_\_\_\_\_

 **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Daily Activities: Effects of Current conditions On Performance**

 Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bending  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Concentrating  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Doing computer Work  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Gardening  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Playing Sports  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Recreation Activities  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Shoveling  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sleeping  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Watching TV | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Carrying | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Dancing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Dressing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Lifting | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Pushing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Rolling Over | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sitting | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Standing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Working | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Climbing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Doing Chores | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Driving | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Performing Sexual Activity | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Reading | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Running | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sitting to Standing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Walking | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |

**Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

**List Prescription & Non-Prescription drugs you take**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at ABSOLUTE HEALTH SOLUTIONS, INC. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_**🗀***Witness Initials*

Patient or Authorized person’s Signature Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY 🡪** *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

🞏 The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-­­­­\_\_\_\_ Date

### 🞏 I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

### By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ **🗀***Witness Initials*

Patient orAuthorized person’s Signature Date