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whole life
CHIROPRACTIC

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Confidential Patient Information

Personal Information **Today's Date** ____/_____/_____

Title: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Rev. ☐ Miss ☐ Prof. ☐ Other: _____

First Name: _____ **Last:** _____ **Middle:** _____ **Preferred Name:** _____

Birth Date: ____ /____/_____ **Gender:** _____ **Marital Status:** _____ **Preferred Language:** _____

Race (check one or more): ☐ American Indian/Native Alaskan ☐ Asian ☐ African American/Black ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Address: _____ **Apt #**_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email Address: _____

Spouses Name: _____ **Children (Names and Ages):** _____

Hobbies/ Interests_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____

☐ Close to home/work ☐ Whole Life website ☐ Google/Internet ☐ Drove by ☐ Physician ☐ Insurance Plan

Employment Information

Business Name: _____ **Work Phone:** (_____) _____-_____

Occupation/Job Title and Description: _____

Emergency Contact

Name: _____

Phone # (____) _____-_____ **Relationship:** ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays on me or on the patient named below for whom I am legally responsible by Dr. Murphy and/or other licensed doctors of chiropractic who now or in the future work at Whole Life Chiropractic, PA.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

Whole Life Chiropractic is a small office with an open adjustment bay and therapy bays. Since your treatments are likely to be performed in these open areas, and though we take many precautions to keep our conversations with you about your treatments confidential, you have the right to ask for your treatment to be discussed in a private area, simply by asking the attending professional.

I have be given the opportunity to read over the Notice of Patient Privacy Policy and can download a copy from www.wholelifedc.com, ask for one at the front desk of Whole Life Chiropractic, or talk with the compliance officer should I have questions. I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Print Name: _____ **Patient's Signature:** _____ **Date:** ____/____/____