

TRUE FUNCTION



Chiropractic & Health

Dr. Aubrey Madsen, DC
612 N. Main St. Suite #1
Kaysville, Utah 84037
801.540.7278

PATIENT _____ AGE _____ DATE _____

INFORMATION

Address _____ Home Phone _____
_____ Work Phone _____
_____ Cell Phone _____

Date of Birth _____ E-Mail _____
Female ____ Male ____ Fax Number _____

Occupation _____ Marital Status _____ No. of Kids ____

HEALTH HISTORY

Main Complaint _____
Other Professionals Seen _____
When did it start? _____
How did it start? _____
Dates of X-rays, MRI, CT _____
Please circle any of the following that are affected by your complaint:
Sleep Work Daily Routine Social Life

Additional Health Concerns _____

Please list and briefly describe any of the following:

Hospitalizations/Surgeries

Trauma/Accidents

Medications

Supplements

HEALTH HISTORY (cont.)

Please circle any of the following that have previously or currently apply to your health:

General

Allergies
Dizziness
Fainting
Fatigue
Fever
Headache
Loss of Sleep
Loss of Weight
Nerve Pain
Numbness/Tingling
Sweats
Tremors

Muscle & Joint

Arthritis
Bursitis
Hernia
Swollen Joints
Scoliosis
Sciatica

Gastrointestinal

Gas/Belching
Constipation
Diarrhea
Hemorrhoids
Intestinal Worms
Jaundice
Nausea
Stomach
Excessive Hunger
Poor Appetite
Vomiting
Vomiting of Blood
Blood in Stool
Heart Burn

Eyes, Ears, Nose, Throat

Asthma
Colds
Deafness
Ear Complaints
Eye Complaints
Hoarseness
Nosebleed
Sinus Infections
Sore Throat

Cardiovascular

Hardening of Arteries
High Blood Pressure
Low Blood Pressure
Chest Pain
Poor Circulation
Pounding Heart Beat
Swollen Ankles

Respiratory

Chronic Cough
Difficulty Breathing
Spitting Up Blood
Spitting Up Phlegm
Wheezing

Genitourinary

Bed-wetting
Blood in Urine
Frequent/Painful Urination
Cloudy Urine
Sexual Dysfunction
Kidney Infection/Stones
Liver/Gallbladder Problems

TRUE FUNCTION



Chiropractic & Health

PAYMENT & OFFICE POLICIES

Payment is due prior to, or at, the time of service. Fees will be explained before professional services are provided. This clinic is not affiliated with any health insurance company and therefore cannot accept insurance as payment. If you have health insurance, you *may* be able to be reimbursed for part of your expenses at our office.

We ask for a 24 hour notice to cancel or change an appointment. Changes made within less than 24 hours may be subject to a **\$20 fee** for each 10 minute time period scheduled.

INFORMED CONSENT

Patients under the care of chiropractic physicians give the doctor permission to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. Chiropractic adjustments and muscle activation are most often beneficial. Other than possible temporary soreness, the mentioned procedures seldomly cause problems. However, underlying pathologies, illnesses, or defects may render the patient susceptible to injury. It is the responsibility of the patient to inform the doctor of such conditions as they are aware of them. Care will then be altered for safety and efficacy as needed.

The patient should understand if at any time they are uncomfortable with treatment or diagnoses they should openly discuss their concerns with the doctor. The patient has the right to, at any time, decide not to receive prescribed treatment. Unlike most medical providers, the nature of chiropractic treatment involves manual therapy and physical contact with the doctor. If patients have emotional or psychological trauma that may interfere with this type of treatment, they should also discuss this with the doctor. Special care will always be taken to assure the patient is as comfortable with treatment as possible. If the doctor sees that chiropractic care and/or muscle activation are not the right treatment the patient will be referred to another practitioner.

PRIVACY NOTICE

Patient information is private and protected by law. It will only be used or disclosed for the purpose of giving care, managing billing, or supporting day-to-day operations in this office. The patient has a right to review their office file and may restrict all or part of their health information. Our privacy manual is available at any time for review and a detailed explanation of the privacy policy is available upon request.

If the patient chooses to contact the doctor by electronic means (i.e. website, Facebook, e-mail, texting, etc) they must understand this is not a secured form of communication and will not guarantee health information is protected.

I have read, understand and agree to the above information:

Patient Name (Please Print) _____

Signature (Patient or Legal Guardian) _____

Doctor's Signature _____

Date _____

