PROmotion
Chiropractic for Every Body

Name _____Age _____ Date of Birth _____

Address_____
Street or PO Box Apt# City State Zip

Phone (Hm) _____ (Cell) _____(Wk) _____
Please indicate your preferred contact number above with a (*).

E-Mail Address _____

Do you prefer to be contacted via text / email / or phone call?

Sex: M F

Marital Status: Single Married Widowed Div. Spouse's Name _____
Spouse's Occupation:_____

How many children? _____
Names & Ages of Children_____
_____

Employer: _____
Occupation (please describe what type of work you do daily) _____
_____

How did you hear about Pro Motion Sports Chiropractic &/or Dr. Jamie?
_____

Have you ever consulted a Doctor of Chiropractic? _____
If yes, who? _____
When? _____ How long were you under care?_____
Did you receive X-rays?_____ MRI?_____ When? _____

Please describe what brings you into the office today:
_____
_____
_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered:

X _____ _____
Signature Date

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Privacy Act:
I consent to the use of my protected health information by Dr. Wuistinger for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance.

X_____ _____ _____
Signature of Patient Printed Name of Patient Date

Do you now, or have you ever suffered from:

Dizziness ___
Diabetes ___
Asthma ___
Neuritis ___
Heart Burn ___
Arthritis ___
Cancer___
Anemia ___
Low Energy___
Anxiety ___
Allergies ___
TB___
Irritability___
Diabetes_____
Infertility_____
Adrenal dysfunction____
Autoimmune Conditions_____
Thyroid Dysfunction____
Difficulty Sleeping ___
Altered Circulation____

Heart trouble ___
Lung problems___
High Blood Pressure ___
Digestive disorder or troubles___
Headaches___
Sinus trouble ___
Nervousness ___
Trouble Sleeping ___
Poor Circulation ___
Menstrual Pain or Difficulties ___
Tire Easily ___
Cold or Tingling in Hands/Feet ___
Depression___
Numbness in Hands/Feet ___
PCOS_____
Cognitive or Concentration Challenges_____
What?_____
Hormone dysfunction____
Memory Changes____

Please describe any listed above: _____
_____
_____

Please list any other health concerns you have at this time: _____
_____
_____

What would you like to re-gain in your life by becoming healthier? _____
_____

What are your goals for your experience here at Pro Motion Sports Chiropractic? _____
_____

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Accidents or Injuries (childhood, broken bones, etc.)?_____
_____

Surgeries:_____
_____

Any Other Medical Procedures?_____
_____

Describe your physical activities (recreation, job, etc): _____
_____
_____

Please list all medications that you take (prescription or OTC): _____
_____
_____

Do you smoke or chew tobacco? _____

Do you drink alcohol, how often?_____

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Terms of Acceptance

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

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

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

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or 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 the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health
care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____
(signature)
(date)

Consent to evaluate and adjust a minor child:

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

For all Female Patients of Child-Bearing capability:
Pregnancy Release

This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Wuistinger has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
(signature)
(date)