DATE: _____ **SUNSHINE CHIROPRACTIC** CHART: _____

Weight: _____ Height: _____ Blood Pressure: _____

List all Surgeries and Dates: _____

_____

Current Medications: _____

_____

_____

Current Vitamins and Minerals: _____

_____

_____

List Anything You are Allergic To:_____

_____

Have you ever seen a Chiropractor before? ☐Yes ☐No If Yes, Who and When? _____

Family Physician _____ Date Last Seen _____

Smoking: ☐Never ☐<1 pack/day ☐1-2 packs/day ☐Over 2 packs/day

Caffeinated Drinks: ☐Never ☐1 glass/day ☐2-3 glasses/day ☐More than 3 glasses/day

Alcohol Consumption: ☐Never ☐1 glass/day ☐2-3 glasses/day ☐More than 3 glasses/day

Exercise: ☐Never ☐1 day/week ☐2-3 days/week ☐More than 4 days/week

Kinds of Exercise: _____

The undersigned agrees to and understands all information of this agreement. I accept financial responsibility for services given regardless of insurance reimbursement to provider. Our policy requires payment in full for all service rendered at the time of visit, unless other arrangements have been made with Sunshine Chiropractic employee. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

I hereby consent to the performance of examination and treatment on my by the licensed doctors of chiropractic, certified therapy assistants and any other technical support staff who may be employed or engaged in practice in this clinic. I understand that while very small, there are certain degrees of risk associated with chiropractic care and with any and all supportive physical therapeutic modalities. These risks include, but are not limited to fracture disc injury, stroke, sprains, strains and soreness. I am therefore willing to accept and consent to the risks associated wit the care I am about to receive.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature ☐Patient ☐Guardian Date