27850 Gratiot Avenue
Roseville, MI 48066
Phone (586) 772-5876
Fax (586) 772-1122

LUPO chiropractic center

CHILD PATIENT INFORMATION CARD

Date _____ Social Security # _____

Name _____ Parent/Guardian _____
Last *First* *Middle Initial*

Address _____ City _____ St _____ Zip _____

Phone _____ Cell _____ E-mail _____

Date of Birth _____ Age _____ ❑ M ❑ F Ht: ___ft. ___in. Wt. _____ Referred By _____

DOES YOUR CHILD HAVE ANY **DIFFICULTY WITH ANY OF THE FOLLOWING? CHECK ALL THAT APPLY:**

❑ Ear Infections	❑ Scoliosis	❑ Fainting or Seizures	❑ Anemia
❑ Asthma	❑ Digestive Problems	❑ ADHD	❑ Abdominal Pain
❑ Diabetes	❑ Bed Wetting	❑ Car Accident	❑ Irritability / Moodiness
❑ Headaches	❑ Sleeping Trouble	❑ Dizziness	❑ Diarrhea / Constipation
❑ Sinus Trouble	❑ Chronic Fatigue	❑ Loss of Balance	❑ Groin Pain
❑ Shortness of Breath	❑ Eye / Vision Trouble	❑ Thyroid Trouble	❑ Knee Pain
❑ Chronic Colds	❑ Pain in Shoulder / Arm	❑ Heart Trouble	❑ Leg / Foot Pain
❑ Recurring Fevers	❑ Chest or Rib Pain	❑ Liver Trouble	❑ Buttocks Pain
❑ Temper Tantrums	❑ Hearing Difficulties	❑ Kidney Trouble	❑ Hip Pain
❑ Cancer	❑ Nerves, Nervousness	❑ Painful Menstruation	❑ Tailbone / Sacrum Pain
❑ Growing / Back Pains	❑ Stress / Anxiety	❑ Irregular Menstruation	❑ Low Back Pain
❑ Neck Pain	❑ Mid Back / Shoulder Blade Pain	❑ Upper Back Pain	❑ Other _____

Other **doctors seen** for this condition _____

List all **surgeries** and when _____

List all **medications / antibiotics** and what they're for _____

Previous chiropractic care? ❑ Yes ❑ No When? _____ Where? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e.: a bed, changing table, down the stairs, etc). **Was this the case with your child?** ❑ Yes ❑ No

Is / has your child been involved in any **high impact or contact type sports?** (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) ❑ Yes ❑ No List any and all accidents, traumas or injuries and dates: _____

Has your child ever been involved in a **car accident**? ❑ Yes ❑ No _____

Has your child ever been seen on an **emergency basis**? ❑ Yes ❑ No _____

Has your child had **any of the following**:

Chicken Pox ❑ Yes ❑ No Age _____ Mumps ❑ Yes ❑ No Age _____ Whooping Cough ❑ Yes ❑ No Age _____

Rubella ❑ Yes ❑ No Age _____ Rubeola ❑ Yes ❑ No Age _____ Other _____ Age _____

Primary / Family Doctor: Name, address, phone _____

Primary Insurance _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

Secondary Insurance _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

Authorization for Care of Minor: I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payments of all fees charged by this office.

Parent/Guardian Signature _____ Date _____

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PEDIATRIC AUTO ACCIDENT

Child's Name _____ Parent/Guardian _____ Date _____

About the Accident

Date _____ Time of day _____ am/pm

Location of accident _____

_____

Direction of impact
❑ Front-end ❑ Rear-end ❑ Rollover
❑ Left side ❑ Right side

Did collision involve
❑ Another vehicle ❑ Other object _____

Non-collision injury
❑ Near-miss ❑ spin out ❑ sudden stop

Child's position in vehicle
❑ front-right ❑ front-left ❑ front center
❑ Rear-right ❑ rear left ❑ rear center

Car seat type
❑ regular seat ❑ infant seat ❑ booster seat
❑ facing front ❑ rear

Was child wearing seat belt
❑ no ❑ yes ❑ lap/sash
❑ lap only ❑ harness

At time of accident child was
❑ facing front ❑ facing left ❑ facing right
❑ asleep ❑ other _____

Were head rests fitted ❑ no ❑ yes

Did the air bags inflate ❑ no ❑ yes

Was child struck by airbag ❑ no ❑ yes

Did the child strike any object within the vehicle ❑ no ❑ yes

Speed of **your** vehicle _____ mph
Speed of **other** vehicle _____ mph

Make and model of your vehicle

_____

Make and model of the other vehicle

_____

Was a police report filed ❑ no ❑ yes

Describe the accident _____

_____

_____

_____

About the Child's Injuries

❑ Child has no apparent symptoms

Please describe any apparent symptoms _____

_____

_____

Do you have other concerns about your child's condition?

_____

_____

Has the child previously been examined or treated since the accident? ❑ Yes ❑ No

Name of hospital or treating doctor

_____

_____ Date _____

Were x-rays taken? ❑ Yes ❑ No

Describe any treatment already received

_____

_____

Is the child's condition
❑ getting better ❑ getting worse
❑ constant ❑ intermittent

When did the symptoms begin?
❑ Immediately ❑ later that day
❑ next day ❑ days later

Does the child complain of any of the following:
❑ Pain or soreness ❑ Joint aches or stiffness
❑ Headaches ❑ Difficulty sleeping
❑ Neck pain ❑ Limited or painful motion
❑ Abdominal pain ❑ Irritability or fatigue
❑ Chest pain ❑ Back pain or stiffness
❑ Leg pain ❑ Nausea
❑ Arm pain ❑ Dizziness

About your Motor Vehicle Insurance Company

Name of your auto insurance company _____

_____

Claims agent _____

agent's phone number _____

Policy number _____

Claim number _____

Signed by _____

Relationship to child _____

Date _____

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CONSENT FOR CARE OF MINOR CHILD

I, _____, request and consent to the release of information for the purpose of treatment at Dr. Joseph Lupo's office **and to administer chiropractic care as deemed necessary to my child**, **_____**.

Parent/Guardian Signature _____ Date _____

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HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ Date _____

What caused this condition? Explain _____

Approximate date this condition began: _____

How frequent do your symptoms occur?
❑ Infrequent (0-25%) ❑ Occasional (26-50%)
❑ Frequent (51-75%) ❑ Constant (76-100%)
❑ On and Off ❑ Random ❑ Recurring

Check the quality of your symptoms
(Check all that apply)**:**
❑ ache ❑ burning ❑ constricting
❑ dull ❑ numbing ❑ pounding
❑ sharp ❑ shooting ❑ spasm
❑ stiffness ❑ stinging ❑ tingling

Does your pain/symptoms radiate: ❑ Yes ❑ No
❑ head ❑ face ❑ shoulders ❑ arm
❑ hands ❑ fingers ❑ buttocks ❑ hip
❑ rear thigh ❑ front thigh ❑ calf ❑ shin
❑ ankle ❑ foot ❑ toes ❑ leg

Is your condition associated with:
❑ Auto Accident ❑ Work Injury ❑ Slip and Fall
❑ Old Age ❑ Other: _____

Is this condition getting progressively worse: ❑ Yes ❑ No

On a scale of 0-10 (10 = the worst) how bad does it get when it's at its worst? 0 1 2 3 4 5 6 7 8 9 10

What Relieves your pain?
❑ chiropractic ❑ cold pack ❑ exercise ❑ heat
❑ massage ❑ nothing ❑ stretching ❑ rest
❑ OTC meds ❑ Rx meds ❑ other_____

What Aggravates your pain?
❑ AM ❑ PM ❑ standing ❑ reaching
❑ sitting ❑ stairs ❑ sneezing ❑ coughing
❑ lifting ❑ bending ❑ neck movement
❑ other_____

Does your pain/symptoms radiate to your:
❑ head ❑ face ❑ shoulders ❑ arms
❑ hands ❑ fingers ❑ buttocks ❑ hip
❑ rear thigh ❑ front thigh ❑ calf ❑ shin
❑ ankle ❑ foot ❑ toes

Is this condition interfering with your:
❑ work ❑ sleep ❑ daily routine
❑ family life ❑ hobbies ❑ libido
❑ social life ❑ other_____

Sleep Disturbance:
Do you have trouble falling asleep? ❑ Yes ❑ No
Do you awaken in middle of the night? ❑ Yes ❑ No
Do you awaken earlier than normal? ❑ Yes ❑ No
Do not feel well-rested? ❑ Yes ❑ No

Other Health Care Providers you have tried:
❑ Family MD ❑ Neurologist ❑ Physical therapist
❑ Massage ❑ Gynecologist ❑ Orthopedic surgeon
❑ Counselor ❑ Proctologist ❑ Gastroenterologist
❑ Psychiatrist ❑ Psychologist ❑ Ear, nose & throat
❑ Hypnotist ❑ Acupuncturist ❑ Endocrinologist
❑ Allergist ❑ Heart specialist ❑ Pulmonary specialist
❑ Internist ❑ Chiropractor ❑ Rheumatologist
❑ Nutritionist ❑ Kidney specialist ❑ Pain specialist/clinic
❑ Other _____

Check off any Diagnostic Tests you have received:
❑ X-Rays ❑ MRI ❑ CT scan
❑ EKG ❑ Allergy test ❑ Nerve test
❑ EMG ❑ Bone scan ❑ Bone density test
❑ Myelogram ❑ Ultrasound ❑ Other
_____

Check off any Treatments you have tried:
❑ OTC meds ❑ Ice ❑ Heat ❑ Prescription Rx meds
❑ Massage ❑ Cortisone shots ❑ Electrical stimulation
❑ Acupuncture ❑ Ultrasound ❑ Physical therapy
❑ Ointments ❑ Surgery ❑ Medical Marijuana
❑ Traction ❑ Manipulation ❑ Other
_____

Work / Occupational Status:
Average Hours per week worked? _____ hours

Do your present complaints affect the number of hours you work per week? ❑ Yes ❑ No

Are you working beyond your physical limitations because you ***have*** to work? ❑ Yes ❑ No

Job involves: ❑ Lifting ❑ Bending ❑ Stooping
❑ Twisting ❑ Turning ❑ Carrying ❑ Walking
❑ Sitting ❑ Other _____

Has this caused you to miss work? ❑Yes ❑No

If so, how much? _____ Last day worked? _____

If **RETIRED**, what occupation did you retire from?
_____

If **DISABLED**, What is your disability and how long have you been disabled?
_____
_____

What was your last employed function?
_____

Patient Name _____

Check any MEDICATIONS you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

(check all that apply)	OTC	Rx
Headaches	❑	❑
Pain *(NSAIDS, etc.)*	❑	❑
Pain *(Opioid/Narcotics)*		❑
Muscle Relaxants	❑	❑
Arthritis	❑	❑
Steriods	❑	❑
Sinus/Allergy	❑	❑
Asthma/Bronchitis	❑	❑

(check all that apply)	OTC	Rx
Diabetes	❑	❑
Water Pills	❑	❑
Heart/Cardiovascular	❑	❑
Blood Pressure	❑	❑
Cholesterol	❑	❑
Ulcers	❑	❑
Depression/Anxiety/Psych	❑	❑
Sleeping/Insomnia	❑	❑

(check all that apply)	OTC	Rx
Bowels/Laxative	❑	❑
Hormones	❑	❑
Thyroid	❑	❑
Antibiotics	❑	❑
Birth Control		❑
Heartburn/Stomach	❑	❑
Other _____	❑	❑
NOT TAKING Medications	❑	❑

Do you have difficulties with any of the following ACTIVITIES? (check all that apply)

❑ Bathing	❑ Drying Hair	❑ Brushing Teeth	❑ Put on shoes	❑ Preparing meals	❑ Put Trash out
❑ Showering	❑ Combing Hair	❑ Making Bed	❑ Tying shoes	❑ Eating	❑ Laundry
❑ Washing Hair	❑ Washing Face	❑ Putting on shirt	❑ Put on pants	❑ Washing dishes	❑ Going to toilet
❑ Standing	❑ Walking	❑ Kneeling	❑ Bending back	❑ Twisting left	❑ Leaning left
❑ Sitting	❑ Stooping	❑ Reaching	❑ Bending left	❑ Twisting right	❑ Leaning right
❑ Reclining	❑ Squatting	❑ Bending forward	❑ Bending right	❑ Leaning forward	❑ Leaning back
❑ Prolong Standing	❑ Prolong sitting	❑ Prolonged walk	❑ Prolong kneel	❑ Climbing inclines	❑ Driving car
❑ Carry objects	❑ Lift from floor	❑ Pushing	❑ Exercise upper	❑ Climbing stairs	❑ Using keyboard
❑ Carry briefcase	❑ Lift from table	❑ Pulling	❑ Exercise lower	❑ Exercise arms	❑ Exercise legs
❑ Bowling	❑ Jogging	❑ Swimming	❑ Ice Skating	❑ Comp Sports	❑ Dating
❑ Golfing	❑ Dancing	❑ Skiing	❑ Roller skating	❑ Hobbies	❑ Dining out
❑ Concentrating	❑ Seeing	❑ Hearing	❑ Touching	❑ Tasting	❑ Smelling

PAST / FAMILY / SOCIAL HISTORY

MEDICATION ALLERGIES (please list)

_____

_____

_____

_____

ALCOHOL & SMOKING "Social Habits":

ALCOHOL: ❑ does not drink ❑ social drinker ❑ light drinker ❑ moderate drinker ❑ alcoholic ❑ recovering alcoholic

CIGARETTE SMOKING: ❑ never smoked ❑ ex-smoker ❑ current some day smoker ❑ current every day smoker

MARIJUANA: ❑ YES ❑ NO **CBD:** ❑ YES ❑ NO

SURGICAL HISTORY: (please list ALL previous surgery and when it was performed)

Surgery	Date	Medical Implants:
_____	_____	_____
_____	_____	_____
_____	_____	Surgical Hardware: _____
_____	_____	_____
_____	_____	_____

Personal Medical History & REVIEW OF SYSTEMS: (please √ any current or past medical problems)

❑ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

FEMALES: Are you PREGNANT?
❑ YES ❑ NO If yes, DUE DATE: _____

Bone & Joint Disorders "Musculoskeletal"

❑ osteoarthritis "OA"	❑ gout	❑ osteomyelitis
❑ rheumatoid arthritis "RA"	❑ lupus "SLE"	❑ ankylosing spondylitis "AS"
❑ other: _____	❑ TMJ dysfunction	❑ fibromyalgia syndrome "FMS"

Neurologic Disorders ❑ *no known neurologic disorders*

❑ stroke or TIA	❑ Parkinson's	❑ cerebral palsy
❑ peripheral neuropathy	❑ MS	❑ polio
❑ other: _____	❑ epilepsy or seizures	❑ diabetic neuropathy

Cardiovascular / Heart and peripheral vascular disease ❑ *no known cardiovascular / heart disorders*

❑ chest pain / angina or tightness	❑ high blood pressure "HBP"	❑ irregular heartbeat, arrhythmia
❑ heart attack, myocardial infarction "MI"	❑ heart murmur, valve disorder	❑ peripheral vascular disease "PVD"
❑ congestive heart failure "CHF"	❑ mitral valve prolapse	❑ deep vein thrombosis "DVT"
❑ other: _____	❑ bleeding problems	❑ blood clots

Lungs / Pulmonary – breathing disorders "Respiratory" ❑ *no known respiratory disorders*

❑ asthma	❑ pulmonary embolism	❑ respiratory arrest
❑ COPD	❑ pneumonia	❑ sleep apnea
❑ emphysema	❑ tuberculosis	❑ other: _____

Patient Name _____

Personal Medical History & REVIEW OF SYSTEMS: (please √ any current or past medical problems) CON'T

Gastrointestinal Disorders ❑ *no known gastrointestinal disorders*
❑ peptic ulcer or stomach ulcer ❑ diverticulitis ❑ hepatitis - Type _____
❑ acid reflux, GERD ❑ irritable bowel ❑ liver disease
❑ GI bleed ❑ inflammatory bowel disease "IBS"
❑ other: _____

Genitourinary Disorders ❑ *no known genitourinary disorders*
❑ urinary tract infection ❑ kidney problems ❑ dialysis, kidney failure
❑ bladder problems ❑ kidney stones ❑ other: _____

Endocrine "Metabolic" & Other Disorders ❑ *no known endocrine or other disorders*
❑ Diabetes, # of _____ years ❑ skin disorder _____ ❑ depression
❑ thyroid problems ❑ psoriasis ❑ anxiety
❑ sickle cell disease ❑ any skin ulcer ❑ alcohol or drug dependency
❑ high cholesterol or lipids ❑ tooth abscess, gingivitis ❑ other: _____

LIFESTYLE HABITS:

EXERCISE: ❑ None ❑ Aerobics ❑ Stretching
❑ Strength Training How often? _____ x/week
❑ Sports? _____
❑ Pilates ❑ Spinning ❑ Step ❑ Yoga ❑ Zumba

NUTRITION: ❑ Standard Diet ❑ Keto
❑ Paleo ❑ Atkins ❑ Weight-Watchers
❑ OTHER (ie Diabetes…) *please list*: _____
_____

Cancer: (*any type*) -- please specify _____

Other medical problems NOT included above (*please explain*) _____
_____
_____
_____

FAMILY HISTORY: (please √ any significant family medical history or problems)

❑ asthma ❑ tuberculosis ❑ sleep apnea
❑ COPD or Emphysema ❑ other lung disease:_____
❑ heart attack, myocardial infarction ❑ congestive heart failure
❑ irregular heartbeat, arrhythmia ❑ bleeding problems
other heart :_____
❑ Peripheral neuropathy ❑ MS or Parkinson's ❑ other neuro :_____
❑ osteoarthritis ❑ Lupus ❑ gout
❑ rheumatoid arthritis ❑ Other bone & joint: _____

❑ hepatitis - Type _____
❑ liver disease ❑ other GI :_____
❑ kidney problems ❑ dialysis, kidney failure
❑ diabetes ❑ psoriasis ❑ high cholesterol or lipids
❑ thyroid problems ❑ sickle cell disease ❑ any skin ulcer
❑ Malignant hyperthermia

Cancer: (*any type*) -- please specify _____

Other medical problems NOT included above (explain) _____

_____
_____

OTHER HEALTH PROVIDERS:

Please list your **Primary Care Physician** and any other **Specialist Doctors** you treat with:

Doctor's Name (MD/DO)	Specialty	Phone #	Location/address

EMERGENCY CONTACT: Name _____ Phone _____ Relationship: _____

Patient Name _____

REQUIRED SIGNATURE FORM

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I hereby authorize the doctor to release all information necessary to any PCP and/or specialist doctor to assist with coordination-of-care.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION: I do hereby authorize you to furnish Lupo Chiropractic Life Center, P.C., with a copy of my records and reports relating to my care, assessment, and treatment of any medical conditions. 1) This Authorization is subject to Public Health Law Sections 17-18 and Health Insurance Portability and Accountability Act (HIPAA) and is to be accepted by the medical provider. 2) I understand that this Authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively. 3) A photocopy of this Authorization has the same effect as the original. If you have any questions whatsoever concerning this Records Release Authorization, please contact Lupo Chiropractic Life Center, P.C. at (586) 772-5876. PLEASE FAX ALL DOCUMENTATION TO: (586) 772-1122, OR MAIL TO: Lupo Chiropractic Life Center, P.C. 27850 Gratiot Ave. Roseville, MI 48066.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize my insurance carrier(s) and/or third party (such as attorney, litigation, etc..) to make payment directly to Lupo Chiropractic for the chiropractic and/or medical benefits payable for the services rendered. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

FINANCIAL AGREEMENT: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. IN ORDER TO KEEP YOUR ACCOUNT CURRENT AND CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME SERVICE IS RENDERED. If this account is assigned to an attorney/or outside agency for collection and/or suit, Lupo Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

NOTICE OF HIPAA PRIVACY PRACTICES: This office conforms to current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.

THE PATIENT-CENTERED MEDICAL HOME NEIGHBORHOOD (PCMH-N) "Specialty Care Practice"

A Patient-Centered Medical Home Neighborhood promotes a close partnership between you and your personal clinical care team. Patients who choose to receive care in this way have the benefit of a medical home, overseen by a team of clinicians of their choice, to help them through today's complex medical system. **Your personal clinical care team**: Is trained to provide first contact, constant and complete care for you. Recognizes the primary care physician as the lead clinical decision maker. Will work together in an organized manner to achieve better health outcomes for you. **You will be expected to**: Actively participate in decision-making and feedback to ensure your expectations are being met. Participate in the health care provider's quality improvement activities. Tell us about all medications and over-the-counter supplements you are taking. Let us know when you see other healthcare providers. Keep your appointments or call to reschedule or cancel. Follow your doctor's medication advice. The Patient-Centered Medical Home Neighborhood includes care for all stages of your life and will ultimately assist you with making your life healthier.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT: I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic at Lupo Chiropractic and/or other assistants and/or licensed practitioners. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

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. **SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____