



Welcome to McFarland Chiropractic

Patient Information

Thank you for choosing **McFarland Chiropractic** for your chiropractic and healthcare needs. Please complete this form in black ink. If you have any questions or concerns, please do not hesitate to ask us for assistance. We are happy to help. *(please print clearly)*

Name: _____ Social Security #: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Female Male Birthdate: _____ Age: _____ Email: _____

Married Widowed Single Minor Separated Divorced Partner

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Text (SMS) Opt-In Consent:

We will be sending communications and reminders by Text (SMS): Please check the Opt-In checkbox below.

Opt-In to Text (SMS)

By checking this box, I consent to receive Text (SMS) from McFarland Chiropractic. Reply STOP to opt-out; Reply HELP for support; Message and data rates may apply; Messaging frequency may vary.

Please mark the checkbox of your cell phone carrier for us to send you text reminders:

AT&T Verizon T-Mobile Cingular Boost MetroPCS Virgin Spectrum Other: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Cell Phone: (____) _____

Person to contact in case of emergency: _____ Phone: (____) _____

How did you hear about us?

Advertisement Attorney Doctor Referral: _____ Health Fair

Insurance Internet Patient Referral _____ Our Website

Doctor's Name
Patient's Name

Workshop Other: _____

CONFIDENTIAL

Family Members

Over 70% of our patients bring in their family members to get adjusted. If you would like to have your children, spouse or significant other checked for subluxations, please check the box below. They can each receive a complimentary examination including computerized surface EMG and X-rays (if necessary) if scheduled within two weeks of you starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care. ***I would like my family members checked for subluxations in the next two weeks.***

Responsible Party Same as above

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (____) _____

Insurance Information

(Please present your insurance card to the front desk for us to make a copy)

Insurance Co.: _____ ID Number: _____

Check here if you are the insured **If No, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#: _____

Do you have additional insurance? Yes No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#: _____ Date employed: _____

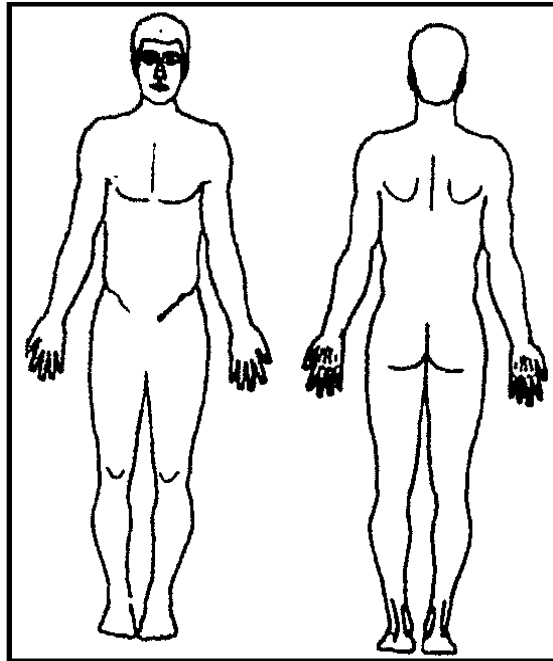
Name of employer: _____ Work Phone: (____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.: _____ ID Number: _____

Symptoms

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Reason for your visit: _____

When did you first notice the symptoms? (Onset Date) _____

How did the problem begin? (Injury/Event) _____

Is the condition getting progressively: better worse staying the same

Where specifically is the problem(s) located? _____

Nature or Type of Pain:

Please write each area below and check the nature of the pain for each area.

Area # 1: _____ Burning Pain Dull Aching Pain Numbness Radiating Pain

Sharp Pain Shooting Pain Tightness Tingling Throbbing

Area # 2: _____ Burning Pain Dull Aching Pain Numbness Radiating Pain

Sharp Pain Shooting Pain Tightness Tingling Throbbing

Area # 3: _____ Burning Pain Dull Aching Pain Numbness Radiating Pain

Sharp Pain Shooting Pain Tightness Tingling Throbbing

Intensity Level of Pain: (0 = no pain or discomfort, to 10 = severe unbearable pain)

Please write each area and circle a number below to rate the severity of your pain for each area.

Area # 1: _____ 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Area # 2: _____ 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Area # 3: _____ 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Daily Activities Affected Level:

Please circle a number below to indicate how much your pain or symptoms interferes with your daily activities? (e.g. work, social activities, or household chores)

Area # 1: _____ 0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Area # 2: _____ 0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Area # 3: _____ 0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Frequency of Symptoms:

Area # 1: _____

0-25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) 76-100% (Constant)

Area # 2: _____

0-25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) 76-100% (Constant)

Area # 3: _____

0-25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) 76-100% (Constant)

Which activities are difficult to perform?

Sitting Standing Walking Bending Lying down Other: _____

What treatment have you received for your condition?

Acupuncture Chiropractic Massage Medication Physical Therapy Surgery

Other: _____

Name and address of other doctor(s) who have treated you for your condition:

Have you had spinal x-rays, MRI, or CT Scan taken for your areas of complaint? Yes No

If yes, please list the date and areas taken: _____

Allergies:

List any types of surgeries which you have had and the dates which they occurred:

Please list all medications you are currently taking:

Dates of last exams:

Women: Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Pregnancy Release: This is to certify that to the best of my knowledge that I am not pregnant and McFarland Chiropractic 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 of Patient, Parent, Guardian or Personal Representative

Date

Daily Habits

What type of exercise do you perform on a daily basis? None Mild Moderate Heavy

What do your daily work habits include? _____

What vitamins/nutritional supplements do you currently take? _____

Do you smoke? Yes No If yes, How much per day? _____

How much alcohol do you consume weekly? _____

How many caffeinated beverages do you consume daily? _____

Personal Health History

Check only those conditions which are applicable:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Corticosteroid Use | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pain unrelieved by position | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures _____ | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Abnormal Weight: |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Other _____ |

Family History

	Mother	Father	Sister 1	Sister 2	Sister 3	Brother 1	Brother 2	Brother 3
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

Constitutional					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Low Libido	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
Eyes					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Blurry or Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Specks
<input type="checkbox"/>	<input type="checkbox"/>	Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Glasses or Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
Ears, Nose, Throat, Mouth					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth
Cardiovascular					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest Tightness
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
Respiratory					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Sputum
Gastrointestinal					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing Difficulties
Genitourinary					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Urgency
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Burning Pain
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Change in Urinary Strength
Musculoskeletal					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Knee Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Foot/Ankle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hip Disorders
<input type="checkbox"/>	<input type="checkbox"/>	TMJ Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture

Integumentary					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
Neurological					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Pins & Needles	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tremor
Psychiatric					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Stressed	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
Endocrine					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
Hematologic/Lymphatic					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Ease of Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Ease of Bleeding
Allergic/Immunologic					
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Staphylococcus Infection	<input type="checkbox"/>	<input type="checkbox"/>	Viral Infection
<input type="checkbox"/>	<input type="checkbox"/>	Bacterial Infection	<input type="checkbox"/>	<input type="checkbox"/>	Streptococcus Infection

Certification

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a healthcare benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I or my minor child have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Assignment of Benefits and Responsibility of Payment

I hereby instruct the _____ insurance co. to pay by check made out to and mailed directly to:

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.
17660 Yorba Linda Blvd.
Yorba Linda, CA 92886

If my current policy prohibits direct payments to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it directly to:

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.
17660 Yorba Linda Blvd.
Yorba Linda, CA 92886

For the professional or medial expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a **direct assignment of my rights and benefits under this policy**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance, deductible, and/or co-pay of said professional service charges over and above this insurance payment.

I further understand that I will be responsible for the payment to any other facilities and /or healthcare providers that I may be referred to by **McFarland Chiropractic or above mentioned doctor** and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be paid by the insurance company or attorney settlement. All professional services are charged directly to the patient, therefore basic responsibility for payment is yours.

_____(INITIAL) I Herby acknowledge and understand that in the event that I do not have insurance that covers chiropractic services or products that all services and products are payable when treatment is rendered and that basic responsibility for payment is mine. I further understand that if I am delinquent on my obligation to pay **McFarland Chiropractic** that I will be responsible for any late fees, interest charges, court cost, attorney fees, and collection charges should the balance not be paid in due diligence.

Name: _____ Birthdate: _____

Social Security # : _____ Driver License #: _____

Patient, Parent, or Guardian Signature

Date

Informed Consent For Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, physiotherapy modalities, therapeutic massage, nutritional/diet counseling and diagnostic x-rays, and supportive therapies on me (or on the patient named below, for whom I am legally responsible) by **McFarland Chiropractic** and the doctor of chiropractic indicated below and/or other licensed doctor's of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine and like other health modalities, results are not guaranteed, and there is not promise of cure. I further 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. I wish to rely on the doctor to exercise judgment during the course of the procedure in which the doctor feels at the time, based on the facts then know, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had 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.

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.

PATIENT'S NAME (PLEASE PRINT)

DATE

SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS A MINOR)

(PLEASE COMPLETE THE INFORMATION ON THE NEXT PAGE IF THE PATIENT IS A MINOR)

Consent to Treatment Of a Minor

Name of responsible party: _____ Social Security #: _____

Relationship to minor: Father Mother Other _____

Address of responsible party: _____

Home phone: _____ Cell phone: _____

Responsible party employed by: _____ Work phone: _____

Employer address: _____ City: _____ Zip: _____

I being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request **McFarland Chiropractic** to administer such treatment deemed advisable, necessary or requested on the above minor. I (We) agree to hold **McFarland Chiropractic** free and harmless from any claims, suits for damages or complication which may result for such treatments.

DATE

SIGNATURE OF PARENT/GUARDIAN

DATE

SIGNATURE OF WITNESS