Murphy Chiropractic & Performance Center
1633 Northwest Blvd. Columbus, OH 43212
(614) 488-1633

PATIENT ENTRANCE FORM

NAME_____ DATE_____

ADDRESS_____

CITY/STATE_____ ZIP CODE_____

HOME PHONE #_____ ALTERNATE PHONE_____

EMAIL ADDRESS_____ DATE OF BIRTH_____

OCCUPATION_____ EMPLOYER_____

WORK ADDRESS_____

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____ PHONE#_____

PRIOR CHIROPRACTIC CARE

NAME_____ LOCATION_____

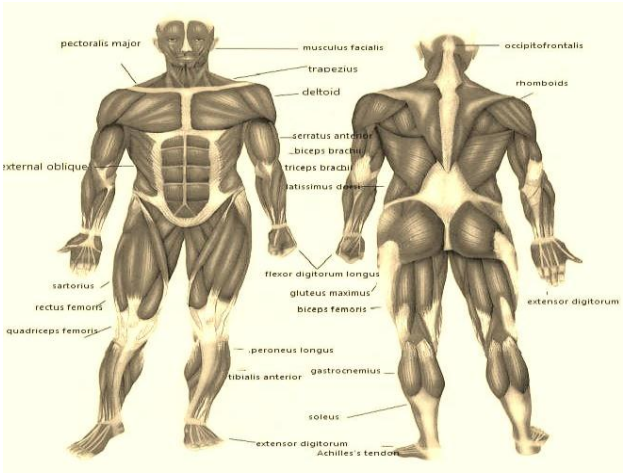
MOST RECENT VISIT_____ XRAYS TAKEN YES / NO DATE_____

MEDICAL DOCTOR NAME_____ PHONE #_____

REASON FOR VISIT_____

REFERRED BY_____

USING THE CHART BELOW, PLEASE MARK YOUR SYMPTOMS ACCORDING TO LOCATION AND TYPE OF PAIN/DISCOMFORT: NUMBNESS ===, BURNING XXX, PINS/NEEDLES +++, DULL ACHE OOO, SHARP/STABBING ///, OTHER >>>



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INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible.)

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. In chiropractic, these risks include but are not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name_____ (Please Print)

Signature of Patient_____

Date Signed_____

TO BE COMPLETED BY PATIENTS REPRESENTATIVE IF PATIENT IS A MINOR

Name of Representative_____(Please Print)

Signature of Representative_____

Date Signed_____

Relationship of Authority of Patient's Representative_____