www.DRFunctionalNeurology.com
Chiropractic & Functional Neurology
972.322.2280 * 972.695.6306 Fax

COMPREHENSIVE ADULT INTAKE FORM

OUR FINANCIAL POLICY

We are committed to the successful completion of your treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full payment is expected at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. We do accept assignment for some insurance providers. For others we will provide you with the necessary paperwork so that you may be re-imbursed by your insurance company.

We realize that due to the rising cost of healthcare, it makes it very difficult for the average person to receive often needed care. It is therefore our policy that no person will be turned away due to financial burdens. We have very flexible payment plans that can fit every budget.

REGARDING INSURANCE

Our policy is to recommend what is best for each patient. What an insurance company may or may not re-imburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into dispute with an insurance company regarding reimbursement. This is the patient's responsibility.

We do not know if your policy covers chiropractic care or not, and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill. Insurance companies do not pay for nutritional supplementation or dietary consultations at this point, although you will be given a superbill that you can submit your insurance company to try and seek re-imbursement.

SCHEDULING OF APPOINTMENTS

One of the most precious gifts is our time. To heal in a timely fashion it is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want. Unless canceled at least **24 hours in advance**, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

I have read the financial policy. I understand and will abide to the terms of the agreement here within.

Name of Patient: _____ (Please print)

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date: _____

PATIENT CASE HISTORY

Name:_____ Birth Date:_____ Age:_____Today's Date:_____

Occupation:_____Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Home Address:_____ Number of children:_____

City:_____State:_____Zipcode:_____

Home Phone#: _____Work Phone#:_____Cell Phone#:_____Pager#:_____

Employer:_____E-mail:_____

Social Security#:_____Driver's License #/State:_____

Spouse's Name:_____Spouse's Occupation:_____ Spouse's Age:_____

Spouse's Employer:_____Spouse's Work#:_____ Cell#:_____Spouse's DOB:_____

Home Address:_____

City:_____State:_____Zipcode:_____

Spouse's S.S.#:_____Spouse's Driver's License #/State:_____

Referred by: _____Relation:_____

Past Chiropractic Care: ☐Yes ☐No Who/When:_____

List health problems that you are currently being treated for:

_____

_____

What types of therapy have you tried for this problem(s)?

☐ Acupuncture ☐ Conventional drugs ☐ Enemas ☐ Herbs ☐ Vitamins/minerals
☐ Chiropractic ☐ Diet modification ☐ Fasting ☐ Homeopathy ☐ Other_____

Are you presently taking any medications (prescription or over the counter)? ☐ No ☐ Yes Explain:_____

_____

_____

Are you presently taking any nutritional supplementation? ☐ No ☐ Yes Explain:_____

_____

_____

_____

Are you recovering from a cold or flu? _____Are you pregnant?_____

What is your current stress level? Please circle, 1 is lowest, 10 is highest: 1 2 3 4 5 6 7 8 9 10

What is the major cause of that stress? ☐ Family ☐ Finances ☐ Health ☐ Job ☐ Legal ☐ Relationship ☐ Other (please specify):

_____

Do you consider yourself: ☐ Just right ☐ Overweight ☐ Underweight What is your weight: _____Height:_____

Please list the region(s) of complaint(s) and severity or severities of complaint(s) below. Please note the severity on a scale of 1 to 10 (1-Least; 10-Greatest): i.e. headaches, worse with movement

1 2 3 ④ 5 6 7 8 9 10

1._____
1 2 3 4 5 6 7 8 9 10

2._____
1 2 3 4 5 6 7 8 9 10

3._____
1 2 3 4 5 6 7 8 9 10

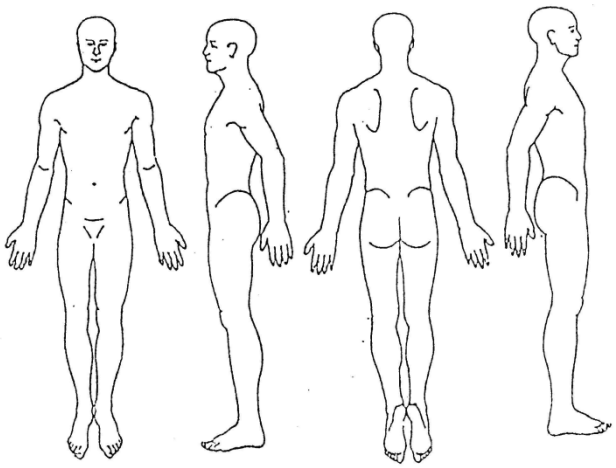
4._____
1 2 3 4 5 6 7 8 9 10

5._____
1 2 3 4 5 6 7 8 9 10

6._____
1 2 3 4 5 6 7 8 9 10

Use the following descriptive symbols. Draw the location of your complaint on the body outline below:

Aching or dull	Burning	Numbness	Tingling/Pins/Needles	Sharp/stabbing	Other
A	**B**	**C**	**T**	**S**	**O**



Have you recently lost or gained 10 pounds or more over the last 3-4 months? _____

Do you wear: ☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical device, prosthetic, etc. _____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ Auto ☐ On the job ☐Personal injury ☐ Other_____

Have you made a report of your accident? ☐ No ☐ Yes ☐ Auto ☐ Employer ☐ Workers compensation ☐ Other_____

Are you now or have you been disabled (Service or work)? ☐ No ☐ Yes When?:_____

Have you retained an attorney? ☐ No ☐ Yes (Name and Address):_____

List any accidents or falls and dates ☐Car_____ ☐Recreational vehicle_____

☐Sports_____☐School_____ ☐Other_____

List any broken bones(fractures) or dislocations:_____

Ever on crutches ☐ No ☐ Yes Explain:_____

Have you ever had any spinal taps or spinal infections? ☐ No ☐ Yes Explain:_____

Were you ever knocked unconscious? ☐ No ☐ Yes Explain:_____

Have you ever had a lapse of memory? ☐ No ☐ Yes Explain:_____

Have you ever had x-rays taken? ☐ No ☐ Yes Explain:_____

Have you ever worked with toxic chemicals (dentistry, photo lab, gas station, etc.)? ☐ No ☐ Yes Explain:_____

_____

Any recent changes in your ability to: ☐ See ☐ Hear ☐ Taste ☐Smell ☐ Feel hot/cold sensation ☐ Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers, etc.)

Strong **LIKE** for any of the following flavors: ☐ None ☐ Bitter ☐ Rich/fatty ☐ Salty ☐ Sour ☐ Spicy/pungent ☐ Sweet

Strong **DISLIKE** for ay of the following flavors: ☐ None ☐ Bitter ☐ Rich/fatty ☐ Salty ☐ Sour ☐ Spicy/pungent ☐ Sweet

Do you prefer: ☐ Warmth (drinks, food, weather, etc.) ☐ Cold (drinks, food, weather, etc.) ☐ No preference
Is your sleep disturbed at the same time each night?_____ If yes, what time?_____

TIME(S) OF DAY YOU FEEL BEST:	***TIME(S) OF DAY YOU FEEL THE WORST:***

☐ 7 a.m. – 9 a.m.	☐ 9 a.m. - 11 a.m.	☐ 11 a.m.– 1 p.m.	☐ 7 a.m. – 9 a.m.	☐ 9 a.m. - 11 a.m.	☐ 11 a.m.– 1 p.m.
☐ 1 p.m. – 3 p.m.	☐ 3 p.m. - 5 p.m.	☐ 5 p.m. – 7 p.m.	☐ 1 p.m. – 3 p.m.	☐ 3 p.m. - 5 p.m.	☐ 5 p.m. – 7 p.m.
☐ 7 p.m. – 9 p.m.	☐ 9 p.m. - 11 p.m.	☐ 11 p.m. – 1 a.m.	☐ 7 p.m. – 9 p.m.	☐ 9 p.m. - 11 p.m.	☐ 11 p.m. – 1 a.m.
☐ 1 a.m. – 3 a.m.	☐ 3 a.m. - 5 a.m.	☐ 5 a.m. – 7 a.m.	☐ 1 a.m. – 3 a.m.	☐ 3 a.m. - 5 a.m.	☐ 5 a.m. – 7 a.m.

DO YOU EXPERIENCE ANY OF THESE GENERAL SYMPTOMS ON A DAILY BASIS?

☐ Bleeding	☐ Depression	☐ Disinterest in sex	☐ Insomnia	☐ Panic attacks
☐ Constipation	☐ Diarrhea	☐ Dizziness	☐ Itching/rash	☐ Shortness of breath
☐ Chronic pain/inflammation	☐ Discharge	☐ Fecal incontinence	☐ Low grade fever	☐ Urinary incontinence
☐ Debilitating fatigue	☐ Disinterest in eating	☐ Headaches	☐ Nausea	☐ Vomiting

OPERATIONS AND PROCEDURES

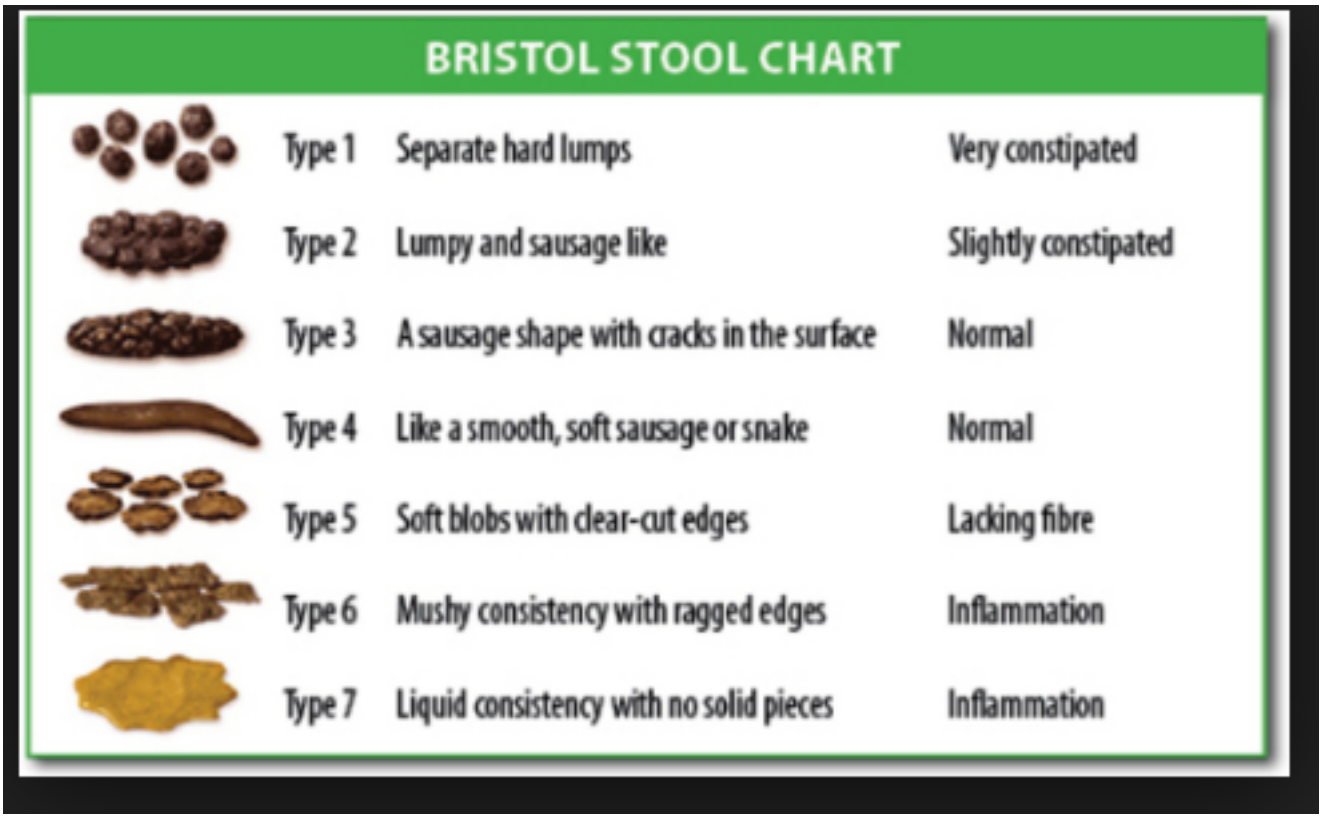
Date		Date		Date	
_____	Vaccinations	_____	Tubes in ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall bladder	_____	Female organs	_____	Thyroid
_____	Back operation	_____	Rectal surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

☐ I have never had any surgeries (includes minor things such as mole removals).

What is your blood type (please mark): ☐ A+ ☐A- ☐ B+ ☐ B- ☐ AB+ ☐ AB- ☐ O+ ☐ O-

How many bowel movements do you have per day (please mark): ☐ 1 ☐ 2 ☐ 3 ☐ every other day ☐ once a week ☐ other_____

Please circle the type of stool you typically produce:



Are there pets at home? ☐Yes ☐No If yes, what type?_____

Are there smokers in the home? ☐Yes ☐No If yes, who? _____

Do you find yourself having any food cravings during the day or night? ☐ Yes ☐ No
If so, what foods?:_____
_____

What is your overall outlook on life? (mark all that apply):	☐ Positive	☐ Negative	☐ Happy	☐ Sad	☐ Depressed	☐ Excited
	☐ Look forward to each day	☐ Difficult to face the day	☐ Angry	☐ Love my life	☐ Don't like my life	☐ Life is awesome

MEDICAL HISTORY

☐ Alcoholism
☐ Allergies_____
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Bruise easily
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Chest pain
☐ Chicken Pox
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Constipation
☐ Deafness
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diarrhea
☐ Diverticular disease
☐ Drug addiction
☐ Ear ache
☐ Eating disorder
☐ Eczema
☐ Epilepsy
☐ Emphysema
☐ Eye, ear, nose, throat probs.
☐ Environmental sensitivities
☐ Fatigue
☐ Fibromyalgia
☐ Food intolerance
☐ Foot trouble
☐ Gastro esophageal reflux dis.
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Hemorrhoids
☐ HIV/AIDS
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Itching
☐ Kidney or bladder disease
☐ Measles
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Mumps
☐ Neurological problems
☐ Night sweats
☐ Nose bleeds
☐ Osteoporosis
☐ Pneumonia
☐ Poor appetite
☐ Poor digestion
☐ Poor memory
☐ Seasonal affective disorder
☐ Sinus problems
☐ Skin problems
☐ Strokes
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
☐ Venereal infection
☐ Whooping Cough
☐ Other _____

MEN ONLY

☐ Benign prostatic hypertrophy
☐ Decreased sex drive
☐ Infertility
☐ Prostate cancer
☐ STD
☐ Sexual abuse

WOMEN ONLY

☐ Breast cancer
☐ Decreased sex drive
☐ Endometriosis
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Infertility
☐ Menstrual irregularities
☐ Pelvic inflammatory disease
☐ PMS
☐ STD
☐ Vaginal infections
☐ Sexual abuse
Age of first period _____
Date of last gyn. exam _____
Mammogram ☐ + ☐ -
PAP ☐ + ☐ -
Form of birth control _____
# of children _____
# of pregnancies_____
☐ C-section_____
☐ Surgical menopause_____
Date of last menstrual cycle___
Length of cycle_____days
Interval between cycles___days
☐ Recent changes in flow____

FAMILY HEALTH

☐ Arthritis, rheumatoid
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraines
☐ Obesity
☐ Osteoporosis
☐ Parkinson's
☐ Paralysis
☐ Stroke
☐ Suicide
☐ Thyroid trouble
☐ Other_____

HEALTH HABITS

☐ Cigarettes #/day_____
☐ Cigars #/day_____
☐ Wine #glass/day/wk___
☐ Beer #glass/day/wk____
☐ Liquor #glass/day/wk__
☐ Coffee #cups/day_____
☐ Teas #cups/day_____
☐ Soda #/day_____
☐ Water #glass/oz/day___

EXERCISE

☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45min workouts
☐ 30-45 min workouts
☐ <30 min workouts
☐ Walk
☐ Jog, run, elliptical, etc.
☐ Weight lift
☐ Swimming
☐ Yoga
☐ Other_____

NUTRITION & DIET

☐ Animal/vegetable source
☐ Atkins diet
☐ Blood type diet
☐ Caloric restriction diet
☐ Carbo restriction
☐ Fat restriction
☐ Fit for life diet
☐ Jenny Craig diet
☐ Salt restriction
☐ See Food Diet (eat it all)
☐ Slim fast diet
☐ South Beach diet
☐ Vegan
☐ Vegetarian
☐ Zone diet
☐ Other

EATING HABITS

☐ 1 meal/day/ when_____
☐ 2 meals/day
☐ 3 meals/day
☐ Eat always even if not hungry
☐ Eat most calories late at night
☐ Eat on the run
☐ Eat plenty of veggies and grains
☐ Eat poorly as a rule
☐ Eat well as a rule
☐ Grazing meals
☐ No appetite
☐ Skip breakfast

SUPPLEMENTS

☐ Acidophilus
☐ Bach flowers
☐ Calcium
☐ CoQ10
☐ Enzymes
☐ Herbal remedies
☐ Homeopathics _____
☐ Magnesium
☐ Minerals
☐ Multivitamin
☐ Natural hormones
☐ Omega 3 oils (EPA/DHA)
☐ Protein shakes
☐ Vitamin B
☐ Vitamin C
☐ Vitamin E
☐ Zinc
☐ Others_____

YOUR HEALTH GOALS

☐ Be more motivated
☐ Be more muscular
☐ Be more organized
☐ Be stronger
☐ Be thinner
☐ Decrease your moodiness
☐ Get in shape
☐ Get out of pain
☐ Get rid of your allergies
☐ Have more endurance
☐ Have more energy
☐ Have stronger nails and hair
☐ Improve the quality of your life
☐ Improve your bowel movements
☐ Improve your complexion
☐ Improve your memory
☐ Increase your sex drive
☐ Look 10 years younger
☐ Regain your youth
☐ Sleep better
☐ Stop being depressed
☐ Stop being indecisive
☐ Stop using medications (OTC)
☐ Think clearly

Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale **(Please Circle)**	0 – Never or almost never have the symptom 1 – Occasionally have it, effect is not severe 2 – Occasionally have it, affect is severe 3 – Frequently have it, effect is not severe 4 – Frequently have it, effect is severe

	Point Score	Complaint		Point Score	Complaint
HEAD	0 1 2 3 4	Headaches	**DIGESTION**	0 1 2 3 4	Nausea, vomiting
	0 1 2 3 4	Faintness		0 1 2 3 4	Diarrhea
	0 1 2 3 4	Dizziness		0 1 2 3 4	Constipation
	0 1 2 3 4	Insomnia		0 1 2 3 4	Bloated feeling
EYES	0 1 2 3 4	Watery or itchy eyes		0 1 2 3 4	Belching/flatulence
	0 1 2 3 4	Swollen, reddened, or sticky eyelids		0 1 2 3 4	Heartburn
	0 1 2 3 4	Bags or dark circles under eyes		0 1 2 3 4	Intestinal/stomach pain
	0 1 2 3 4	Blurred or tunnel vision	**JOINTS/MUSCLE**	0 1 2 3 4	Pain or aches in joints
EARS	0 1 2 3 4	Itchy ears		0 1 2 3 4	Arthritis
	0 1 2 3 4	Earaches/infections		0 1 2 3 4	Stiffness or limitation of movement
	0 1 2 3 4	Drainage from ear		0 1 2 3 4	Pain or aches in muscles
	0 1 2 3 4	Ringing/hearing loss		0 1 2 3 4	Feeling of weakness or tiredness
NOSE	0 1 2 3 4	Stuffy nose	**WEIGHT**	0 1 2 3 4	Bing eating/drinking
	0 1 2 3 4	Sinus problems		0 1 2 3 4	Craving certain foods
	0 1 2 3 4	Hay fever		0 1 2 3 4	Excessive weight
	0 1 2 3 4	Sneezing attacks		0 1 2 3 4	Compulsive eating
	0 1 2 3 4	Excessive mucous formation		0 1 2 3 4	Water retention
MOUTH/THROAT	0 1 2 3 4	Chronic coughing		0 1 2 3 4	Underweight
	0 1 2 3 4	Gagging, frequent need to clear throat	**ENERGY/ACTIVITY**	0 1 2 3 4	Fatigue
	0 1 2 3 4	Sore throat, hoarseness, loss of voice		0 1 2 3 4	Apathy, lethargy
	0 1 2 3 4	Swollen or discolored tongue, gums, lips		0 1 2 3 4	Hyperactivity
	0 1 2 3 4	Canker sores		0 1 2 3 4	Restlessness
SKIN	0 1 2 3 4	Acne	**MIND**	0 1 2 3 4	Poor memory
	0 1 2 3 4	Hives, rashes or dry skin		0 1 2 3 4	Confusion, poor comprehension
	0 1 2 3 4	Hair loss		0 1 2 3 4	Poor physical coordination
	0 1 2 3 4	Flushing, hot flashes		0 1 2 3 4	Difficulty in making decisions
	0 1 2 3 4	Excessive sweating		0 1 2 3 4	Stuttering or stammering
HEART	0 1 2 3 4	Irregular or skipped heartbeat		0 1 2 3 4	Slurred speech
	0 1 2 3 4	Rapid or pounding heartbeat		0 1 2 3 4	Learning disabilities
	0 1 2 3 4	Chest pain	**EMOTIONS**	0 1 2 3 4	Mood swings
LUNGS	0 1 2 3 4	Chest congestion		0 1 2 3 4	Anxiety, irritability, aggressiveness
	0 1 2 3 4	Asthma/bronchitis		0 1 2 3 4	Depression
	0 1 2 3 4	Shortness of breath	**OTHER**	0 1 2 3 4	Frequent illness
	0 1 2 3 4	Difficulty breathing		0 1 2 3 4	Frequent or urgent urination
				0 1 2 3 4	Genital itch or discharge
Score totals			Score totals		

Adapted from Metagenics and ImmunoLaboratories, Inc. 1997.

Review of Systems©

Please circle any of these that apply

Constitutional:	Growth problems	Fatigue	Fevers
	Weight loss	Weight gain	Poor appetite
	Chills	Obesity	Muscle wasting
Eyes	Blurred vision	Double vision	Drainage
	Glaucoma	Diabetes	Near sighted
	Far sighted	Use glasses	Color blindness
	Floaters	Cataracts	Use contacts
Nose/Throat	Loss of smell	Ringing in ears	Current/chronic Infections
	Dryness eyes/nose	Swelling nose/throat	Dizziness
	Drooling	Adenoids	Recent/chronic yeast infection
	Lip tie at birth		
	Ulcers		Tongue tie at birth
Cardiovascular	Blue lips	Blue fingers	Swelling feet
	Hypertension	Tobacco use	Regurgitation
	Swelling hands	Cold feet	Cold hands
	Red hands	White hands	Murmurs
	Chest pain with rest	Chest pain with exertion	Congestive heart failure
Respiratory	Persistent cough	Shortness of breath at rest	Shortness of breath with exertion
	Asthma	Bronchitis	
Gastro-intestinal	Belly pain	Constipation	Diarrhea
	Reflux	Vomitting	Nausea
	Gas/Bloating	Belching	Loss of control
Gastro-urinary	Difficulty urinating	Bed-wetting	Blood
	Late night urination	Loss of control	Urinary incontinence
	Bowel incontinence		
Musculoskeletal	Pain	Problems walking	Weakness
	Arthritis	Joint pain	Problems moving
Skin and hair	Itching	Rashes	Lesions
	Eczema	Allergies	White lines on nails
	Ingrown hair	Dryness	Excessive sweating
	Absent sweating		

Neurological/ developmental	Seizures	Floppy tone	Cerebal palsy
	Fainting	Headaches	Epilepsy
	Multiple sclerosis	Incoordination	Stroke
	Autism	ADD	ADHD
	Parkinson's	Traumatic brain injury	Concussion
	Erb's palsy	Klumpke's palsy	Arnold chiari malformation
	Patent foramen ovale		
	Aspergers	Visual midline shift	Muscular dystrophy
Blood/Lymph	Bleeding	Bruising easily	Swelling
	Diabetes	Poor wound healing	Recent transfusion
Endocrine	Hair loss	Hormone replacement	Hyperthyroidism
	Hypothyroidism	Hashimoto's	
Allergic/Immunologic	Environmental	Seasonal	Auto-immune
	Latex	Anaesthesia problems	Drug allergies
Psychiatric	Behavioural changes	Personality changes	Sadness
	Mania	Agitation	Visual hallucinations
	Anxiety	Obsessive	Auditory hallucinations
	Bipolar	Psychosis	Self injuring
	Sadistic	Depression	OCD
	Suicial thoughts		
Sleep	Problems getting to sleep	Problems staying asleep	Sleep walking
	Well rested after sleep	Enjoy naps	
Genetic	Ehlers-Danlos Syndrome	Cystic fibrosis	
	MECP2	CDKL5	Downs Syndrome
Corrective and/or supportive devices	AFO	Shoes	Leg brace
	Spinal brace	Arm brace	Helmet
	Wheelchair	Crutches	Cane
Hand dominance	Right	Left	Don't know
Foot dominance	Right	Left	Don't know
Eye dominance	Right	Left	Don't know
Ear dominance	Right	Left	Don't know

Family Health History©

Please mark any of these that apply

Family History	Heart disease	Vascular	Cancer	Thyroid	Obesity	Diabetes	Genetics	Other
Father								
Mother								
Brother 1								
Brother 2								
Brother 3								
Sister 1								
Sister 2								
Sister 3								
Grandfather (Father's side)								
Grandmother (Father's side)								
Uncle 1 (Father's side)								
Uncle 2 (Father's side)								
Aunt 1 (Father's side)								
Aunt 2 (Father's side)								
Grandfather (Mother's side)								
Grandfather (Mother's side)								
Uncle 1 (Mother's side)								
Uncle 2 (Mother's side)								
Aunt 1 (Mother's side)								
Aunt 2 (Mother's side)								
© Dr. David Rosenthal								

Do you suffer from any condition other than that for which you are now consulting us? ☐ No ☐ Yes Explain:

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AUTHORIZATION FOR EVALUATION, MANAGEMENT AND SUPPORT

I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for all payments. There are inherent risks in every health care delivery system. Chiropractic health care is no exception. We want you to be informed of potential events associated with chiropractic health care before consenting to evaluation, management and support.

I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize Dr. David Rosenthal to examine and manage my condition as he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. Chiropractic manipulation/adjustment is the introduction of energy with the use of the Doctor's hands or with calibrated instruments. Frequently the maneuvers are associated with a "pop" or "click" sound or sensation in the area being evaluated, managed or supported.

Dr. Rosenthal will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I understand that management and recommendations involve the use of chiropractic care and may or may not incorporate various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, hydrotherapy, dietary modification, exercise recommendations, brain-based rehabilitation, and nutritional supplementation.

I am fully aware and agree to the statements below with my initials:

1.	_____Initials	I am fully aware and agree that Dr. David Rosenthal is licensed in the state of Texas as a Doctor of Chiropractic (DC) and not a medical doctor (md).
2.	_____Initials	I am fully aware and agree that Dr. Rosenthal is not licensed as a primary care physician in the state of Texas and that if I do have a diagnosable medical condition will seek care from a medical physician licensed to treat my specific diagnosis, condition, or disease process. I will not hold Dr. Rosenthal liable for being a primary care physician in the state of Texas.
3.	_____Initials	I am fully aware and agree that Dr. Rosenthal may make recommendations to manage my case that may include: diet, brain-based exercises, nutritional advice, and nutritional supplementation. I understand that nutrition is not an exact science. I acknowledge that no claims or guarantees have been made to me regarding me or my child's (ward's) as a result of Dr. Rosenthal's chiropractic care.
4.	_____Initials	**POSSIBLE RISKS:** As with any health care procedure, complications are possible following chiropractic intervention. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The risks of stroke complications due to chiropractic treatment are so rare that no statistical literature is available to calculate possibility. The risk of cerebrovascular injury, or stroke, has been estimated between one in one million and one in twenty million manipulations/adjustments. The probability of adverse reactions due to ancillary procedures are also so rare that no statistical literature is available to calculate.
5.	_____Initials	I agree to accept full responsibility for applying the advice I receive and for any risk that may be involved in applying these chiropractic procedures and/or principles.
6.	_____Initials	I am fully aware and agree that Dr. Rosenthal does not prescribe any allopathic medical treatments or pharmaceutical medications.

7.	_____Initials	I am fully aware and agree that nutritional recommendations including vitamins, minerals, herbals and homeopathics are used for support and educational purposes only and not intended to render medical advice or serve as any treatment protocol for any pathology, disease or disorder. The nutritional protocols are used to support various body systems. The products recommended are only intended as support for natural metabolic processes that are under temporary stress or to address an additional demand for nutrients. These recommendations have not been evaluated by the Food and Drug Administration and should not be construed as claims to treat, cure or prevent disease, as they are not intended to act as drugs nor to replace any drug prescribe by a physician. We believe that such an act may be detrimental to the health and well being of an individual and that dietary supplements should only be used in a supportive role in such conditions.
8.	_____Initials	I am fully aware and agree that there are **POSSIBLE RISKS OF REMAINING UNMANAGED OR SUPPORTED:** Delay of management and support allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of management and support will complicate the condition and make future rehabilitation more difficult. We will always provide you with our best care; and, if results are suboptimal or finding indicate, we will refer you to another provider who will assist you with your condition.
9.	_____Initials	I agree that no pictures and or videos in analog or digital form will be allowed without the express written permission of Dr. Rosenthal.
10.	_____Initials	I affirm and agree that I am indeed the patient or guardian/ward listed in this paperwork and do affirm that I/we have the listed health complaints and I/we are not part of an investigatory body including local, state or federal commissions involved with health care, legal bodies, insurance investigators, chiropractic and/or medical boards and investigations.
11.	_____Initials	I affirm and agree that I have received a dated copy of this authorization for care form.

Patient Name: _____Date:_____ (Please Print)

Patient Signature: _____Date:_____

Signature of Parent or

Legal Guardian/Ward: _____Date:_____