

# BodyDoc Chiropractic

“Better Health for a Better Life through Chiropractic Care”  
Jeffrey R. Potts, D.C.

## New Patient Information

Welcome to our office! Please complete all questions.

Name:	Date:
Address:	City, State, Zip
Home Phone:	Work Phone:
Cell Phone:	
Email Address:	
Birth Date:	Age:
Marital Status:    M    W    D    S	
Your Employer:	Occupation:
Spouse's Name:	Spouse's Employer:
Children's Names and Ages:	
Sports, Hobbies and Interests:	
Method of Payment for First Visit:    Cash    Check    Credit Card	

Who may we thank for referring you? \_\_\_\_\_

Current health concerns/ reason for consulting our office?

1. \_\_\_\_\_
2. \_\_\_\_\_

Is this a result of an auto accident or work injury?                      Yes                      No

If so, when? \_\_\_\_\_

Have you had the same or similar problems before?                      Yes                      No

If so, for how long? \_\_\_\_\_

Other doctors you have seen for this problem? \_\_\_\_\_

If so, who? \_\_\_\_\_

Father, mother, brother, sister, child with similar problem?                      Yes                      No

Is there any chance you may be pregnant?                      Yes                      No

Do you have health insurance?                      Yes                      No

Name of company \_\_\_\_\_

The above information is true and accurate to the best of my knowledge.

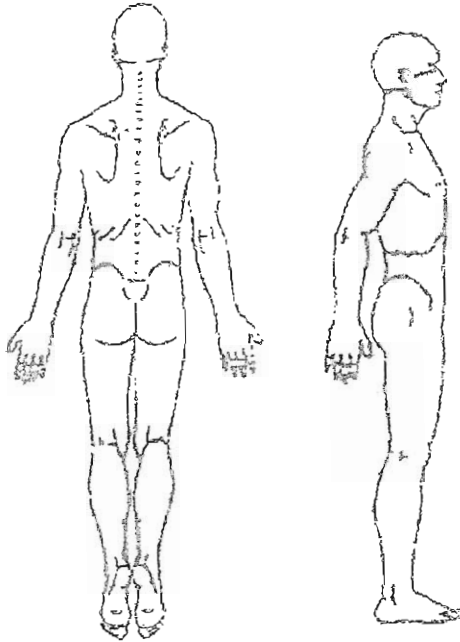
Patient or Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

I have had an opportunity to review the Privacy Policy \_\_\_\_\_

Please circle any areas of pain or discomfort

Surgeries I've had:



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bones I've broken:

\_\_\_\_\_  
\_\_\_\_\_

Medications I take (Rx, OTC, herbal, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check any health conditions you currently suffer from**

- Headaches/migraines
- Dizziness
- Fatigue
- Bronchitis
- Diarrhea/constipation/IBS
- Bladder problems
- High cholesterol
- Osteoporosis
- Cancer \_\_\_\_\_
- Allergies/sinus problems
- Depression
- Asthma/wheezing
- Heartburn/acid reflux
- Gas/bloating
- Prostate problems
- Diabetes
- Arthritis \_\_\_\_\_
- Other \_\_\_\_\_
- Vision problems
- Anxiety/high stress
- Difficulty breathing
- Indigestion
- Kidney stones
- PMS/post-menopausal
- High blood pressure
- Sleep problems
- Other \_\_\_\_\_

**Traumas-** By the time we reach adulthood, we've had dozens of impacts that cause subluxations

**Vehicle Accidents**

Date \_\_\_\_\_ Front Rear Side Rollover Spinout \_\_\_\_\_ Speed \_\_\_\_\_

Date \_\_\_\_\_ Front Rear Side Rollover Spinout \_\_\_\_\_ Speed \_\_\_\_\_

**Work related injuries (slips, falls, repetitive stresses)**

Date \_\_\_\_\_ Type \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

**Sports- currently involved in, played in HS or college**

Date \_\_\_\_\_ Sport \_\_\_\_\_ Injury \_\_\_\_\_

Date \_\_\_\_\_ Sport \_\_\_\_\_ Injury \_\_\_\_\_

**Home- slips, falls, childhood injuries**

Date \_\_\_\_\_ Type \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

## **Informed Consent For Chiropractic Care**

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

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I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

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Patient Name (printed)

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Relationship to patient

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Patient or legal Guardian Signature

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Date

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Witness Signature (office staff)

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Date

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

**ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE **X** \_\_\_\_\_ (Date)  
(Or Patient Representative) \_\_\_\_\_ (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** \_\_\_\_\_ (Date)

**ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE**

## CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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 of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I 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, and 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 an 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.

PATIENT SIGNATURE	<b>X</b>	(Date)
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(Or Patient Representative) (Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**