CHIROPRACTIC INTAKE, CONSENT & RELEASE

PATIENT INFORMATION

Name: _____ **DOB:** _____

Phone: _____ **Email:**_____

Address:

_____

Emergency Contact: _____ **Phone:** _____

TODAY'S VISIT

Main reason for your visit:

_____

Where are you experiencing pain or discomfort? _____

How long have you had this problem?

_____

Pain level today (0–10): _____

Have you received chiropractic care before? ☐ Yes ☐ No

HEALTH INFORMATION

Please check any that apply:

☐ Recent injury/accident
☐ Recent surgery
☐ Osteoporosis/bone weakness
☐ Blood thinner use
☐ Heart/cardiovascular condition
☐ Cancer
☐ Numbness/tingling/weakness
☐ Pregnant/Possibly pregnant
☐ Other significant health condition: _____

Current medications or important health information:

CHIROPRACTIC CONSENT & RELEASE

I voluntarily consent to chiropractic evaluation and treatment at **WellConsulted**, which may include chiropractic adjustments/manipulation, mobilization, stretching, soft-tissue techniques, and other appropriate procedures.

I understand that chiropractic care has potential risks, including temporary soreness, stiffness, increased discomfort, bruising, dizziness, or other reactions. More serious complications are uncommon but may occur. No specific outcome or result has been guaranteed.

I confirm that the health information I have provided is accurate to the best of my knowledge. I understand that I may ask questions, decline any procedure, or discontinue treatment at any time.

By signing below, I acknowledge the potential risks and voluntarily consent to treatment. I accept the ordinary risks associated with chiropractic care and release WellConsulted and its treating providers from claims arising from those ordinary risks, except where prohibited by law.

Patient/Guardian Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

WellConsulted