Date:_____

NRCT PATIENT HISTORY FORM

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ DL#/State: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Employer(s): _____ Work Phone: _____

Type of Work: _____

Status: ☐Single ☐Domestic Partnership ☐Married ☐Widowed ☐Separated ☐Divorced

Spouse: _____ Employer(s): _____

Type of Work: _____

Work Phone: _____ Cell Phone: _____

Name(s) & Age(s) of Children: _____

Is Spouse the Emergency Contact? ☐ Yes ☐ No

Alternate Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Responsible Parties for Bill: ☒Yourself ☐Spouse ☐Worker's Comp ☐ Medicare ☐Medicaid ☐ Auto Insurance[+]

☐Personal Health Insurance[^] ☐Other: _____

[^]*Health Insurance card must be presented.* [+] *If Auto Insurance, please provide claim/policy information.*

Please list any Medical Doctor, Chiropractors or Acupuncturists seen for this condition; date, diagnosis, treatment and the effects their treatment had on your condition.

Date:_____

When did your symptoms begin?_____

Have you been diagnosed with Fibromyalgia? ☐ Yes ☐ No If Yes, When:_____

CURRENT MEDICATIONS

Please list the medications you are currently taking. List the medical condition for which you are taking the medication. List the dosage of the medication. List the frequency of medication. If prescribed as needed, estimate the amount taken over time. Place a NA in the blank if you do not take any medications.

CURRENT MEDICATIONS	TAKEN FOR	DOSAGE	FREQUENCY
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

CHANGES IN CURRENT MEDICATIONS IN THE PAST 6 MONTHS

Please list the medications you are currently taking. List the medical condition for which you are taking the medication. List the dosage of the medication. List the frequency of medication. If prescribed as needed, estimate the amount taken over time. Place a NA in the blank if you do not take any medications.

CURRENT MEDICATIONS	TAKEN FOR	DOSAGE	FREQUENCY
1)			
2)			
3)			
4)			

Date:_____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

PAIN INTENSITY RATING SCALE

FREQUENCY: Using a scale of 0-7, circle a number in the frequency column indicating the average quantity of days per week you experience each symptom.
INTENSITY: Using a scale of 0-10, circle a number in the intensity column indicating In the average intensity of your symptom. Selecting "0" will indicate "no pain" while 10 will indicate "severe pain."
In both columns, be sure to select only one number. Consider how you have felt over the last month and use that as your baseline for your answers. If you are on medications, do not guess how you might feel without your medications; make your selection based on how you feel while on these medications.

	FREQUENCY	INTENSITY
HEAD		
Headache	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Whole Head	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Back of Head	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Forehead	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Temple – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Temple – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Migraine	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
"Heavy" Head	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Memory Loss	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hearing Loss	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Pain in Ears	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Smell Loss	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Taste Loss	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Balance Loss	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Eye Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Light Sensitivity	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Blurred Vision	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Fainting	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Lightheaded	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Dizziness	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ear Ringing	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

Date:_____

	FREQUENCY	INTENSITY
Ears Buzzing	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Facial Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Facial Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Teeth Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
NECK		
Neck Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Movement Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Feels Out of Place	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Stiff Neck	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Muscle Spasm	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Neck Grinds	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Difficulty Swallowing	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Popping	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Nerve Feels Pinched	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
SHOULDERS/ARMS		
Shoulder Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Shoulder Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Across Shoulder Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Shoulder Nerve Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Shoulder Nerve Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Shoulder Spasm	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Tense Across Shoulders	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Unable to Lift Arm Above Shoulder	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Unable to Lift Arm Over Head	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Arm Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Arm Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Forearm Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Forearm Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Wrist Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Wrist Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Swelling – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Swelling – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Arthritis – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hand Arthritis – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Finger Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Finger Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Weak Grip – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Weak Grip – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Cold Hands	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

Date:_____

MID-BACK/CHEST

	FREQUENCY	INTENSITY
Mid-Back Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Mid-Back Spasms	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Pain Between Shoulder Blades	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Chest Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ribs – Right Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ribs – Left Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Shortness of Breath	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

LOW BACK

Low Back Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Working	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Lifting	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Stooping	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Sitting	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Bending	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Coughing	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
When Lying Down	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Low Back Out	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Muscle Spasms	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Arthritis	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

ABDOMEN

Nausea	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Gas	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Constipation	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Diarrhea	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Abdominal Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Menstrual Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Menstrual Cramping	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Menstrual Irregularity	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

HIPS/LEGS/FEET

Buttock Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Buttock Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hip Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Hip Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Leg Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Leg Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Leg Cramps – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Leg Cramps – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Leg – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Leg – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Thigh Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Thigh Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

Date:_____

	FREQUENCY	INTENSITY
Ankle Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ankle Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ankle Swelling – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Ankle Swelling – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Foot – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Foot – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Cold Feet – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Cold Feet – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Burning Feet – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Burning Feet – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Cramps – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Cramps – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Swelling – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foot Swelling – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Toes – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Numb Toes – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Toe Pain – Right	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Toe Pain – Left	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
GENERAL		
Fatigued	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Teeth Grinding	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Run Down Feeling	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Insomnia	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Restless Legs	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Skin Itches	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Waking Up Exhausted	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Irritable Bowel Syndrome	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Asthma or Hay Fever	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Forgetfulness	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Foggy Minded	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Difficulty Breathing	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Skin Sensitivity	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Overall Body Pain	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Chronic Fatigue	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
PHYSIOLOGICAL		
Suicidal Feelings	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Suicidal Plans	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Suicidal Attempts	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Depressed	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Nervousness	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Anxiety	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

Date:_____

	FREQUENCY	INTENSITY
Irritable	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10
Loss of Periods of Time	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7 8 9 10

ACTIVITIES THAT AFFECT YOUR CONDITION

Walking	☐ Better	☐Worse	☐ No Affect/Not Applicable
Swimming	☐ Better	☐Worse	☐ No Affect/Not Applicable
Sleeping	☐ Better	☐Worse	☐ No Affect/Not Applicable
Working	☐ Better	☐Worse	☐ No Affect/Not Applicable
Lifting	☐ Better	☐Worse	☐ No Affect/Not Applicable
Bending	☐ Better	☐Worse	☐ No Affect/Not Applicable
Stooping	☐ Better	☐Worse	☐ No Affect/Not Applicable
Pulling	☐ Better	☐Worse	☐ No Affect/Not Applicable
Exercise	☐ Better	☐Worse	☐ No Affect/Not Applicable
Intercourse	☐ Better	☐Worse	☐ No Affect/Not Applicable
_____	☐ Better	☐Worse	☐ No Affect/Not Applicable
_____	☐ Better	☐Worse	☐ No Affect/Not Applicable
_____	☐ Better	☐Worse	☐ No Affect/Not Applicable

How many hours do you sleep each day? _____

How many hours do you spend in bed each day?_____

GLOBAL HEALTH SCALE

Please rate your general well-being:

(Poor) 0 1 2 3 4 5 6 7 8 9 10 *(Good)*

SURGERIES

Please answer the questions to the best of your knowledge and be as specific as possible in giving date information. If you have not had any surgeries, please write NA in the blanks below and do not answer questions A, B, and C.

Please list one surgery performed with the intent to help your condition and the date of the surgery.

1) _____

Please select the answer that best applies.

A. Did the surgery affect your symptoms? ☐ Yes ☐ No ** If No, skip B & C*

B. Were your symptoms increased? ☐ Yes ☐ No

C. Were your symptoms decreased? ☐ Yes ☐ No

Please list one surgery performed with the intent to help your condition and the date of the surgery.

2) _____

Please select the answer that best applies.

A. Did the surgery affect your symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your symptoms increased? ☐ Yes ☐ No
C. Were your symptoms decreased? ☐ Yes ☐ No

Please list one surgery performed with the intent to help your condition and the date of the surgery.

3) _____

Please select the answer that best applies.

A. Did the surgery affect your symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your symptoms increased? ☐ Yes ☐ No
C. Were your symptoms decreased? ☐ Yes ☐ No

Please list one surgery performed with the intent to help your condition and the date of the surgery.

4) _____

Please select the answer that best applies.

A. Did the surgery affect your symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your symptoms increased? ☐ Yes ☐ No
C. Were your symptoms decreased? ☐ Yes ☐ No

Please list one surgery performed with the intent to help your condition and the date of the surgery.

5) _____

Please select the answer that best applies.

A. Did the surgery affect your symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your symptoms increased? ☐ Yes ☐ No
C. Were your symptoms decreased? ☐ Yes ☐ No

OTHER ILLNESSES REQUIRING SURGERY

Please list any other physical illnesses diagnosed which required surgery. Answer the questions to the best of your knowledge and be as specific as possible in giving date information. Please write NA in the blanks below.

Please list one physical illness, the related surgery, and the date of the surgery.

1) _____

Date:_____

Please select the answer that best applies.

A. Did the surgery affect your primary condition symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your primary condition symptoms increased? ☐ Yes ☐ No
C. Were your primary condition symptoms decreased? ☐ Yes ☐ No

Please list one physical illness, the related surgery, and the date of the surgery.

2)_____

Please select the answer that best applies.

A. Did the surgery affect your primary condition symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your primary condition symptoms increased? ☐ Yes ☐ No
C. Were your primary condition symptoms decreased? ☐ Yes ☐ No

Please list one physical illness, the related surgery, and the date of the surgery.

3)_____

Please select the answer that best applies.

A. Did the surgery affect your primary condition symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your primary condition symptoms increased? ☐ Yes ☐ No
C. Were your primary condition symptoms decreased? ☐ Yes ☐ No

Please list one physical illness, the related surgery, and the date of the surgery.

4)_____

Please select the answer that best applies.

A. Did the surgery affect your primary condition symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your primary condition symptoms increased? ☐ Yes ☐ No
C. Were your primary condition symptoms decreased? ☐ Yes ☐ No

Please list one physical illness, the related surgery, and the date of the surgery.

5)_____

Please select the answer that best applies.

A. Did the surgery affect your primary condition symptoms? ☐ Yes ☐ No ** If No, skip B & C*
B. Were your primary condition symptoms increased? ☐ Yes ☐ No
C. Were your primary condition symptoms decreased? ☐ Yes ☐ No

Date:_____

PSYCHOLOGICAL HEALTH

Please list any psychological diagnoses. Answer the questions to the best of your knowledge and be as specific as possible in giving date information. If you do not have a diagnosed psychiatric illness, please indicate NA.

	DIAGNOSIS	DATE
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Corcetti Chiropractic and Rehabilitation Centre will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any other amount authorized to be paid directly to Corcetti Chiropractic and Rehabilitation Centre will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. The patient agrees that he/she is responsible for all bills incurred at this office.

Patient Signature_____ Date _____

Consent to Treat a Minor_____ Date _____

Guardian or Spouse's _____ Date _____

Signature Authorizing Care