

Goodman Chiropractic Centers
Kenny Goodman, DC J. Garett Goodman, DC
P.O. Box 1206 Thatcher, AZ 85552
P.O. Box 1117 Clifton, AZ 85533

Patient's Name: _____ Date: _____

Please list all serious illnesses and serious accidents: **Month and Year** **City, State**

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis <input type="checkbox"/> Yes	Lung Disease <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="checkbox"/> Yes	Stomach/Ulcer <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="checkbox"/> Yes	Blood Pressure <input type="checkbox"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes

Any other condition(s) not listed above that the doctor should be made aware of:

YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (____) _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (____) _____ Fax: (____) _____

HIPAA Compliance

Goodman Chiropractic Centers are required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Staff Initials: _____

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Informed Consent

The nature of the chiropractic manipulation: I will use either my hands an instrument or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: Ice, Moist Heat Packs, Electrical Muscle/Interferential Stimulations, Stretching/Strengthening Exercises, Neuromuscular Re-education, and Mechanical/Decompression Traction

Risks involved with the recommended ancillary treatments: Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Mechanical Traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure or the anesthesia or both.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name _____ Date _____

Patient Signature _____ Dr. _____

The patient had the following questions and was supplied the following answers:

It is my clinical opinion this patient is oriented to time and space: Yes No

It is my clinical opinion this patient was able to understand the language involved: Yes No