Kevin McAlpin, D.C.

Date:_____

RESPONSIBLE PARTY:

_____

Last Name First Name Middle Name

_____

Date of Birth Social Security Number Gender

_____

Street Address OR PO Box Number City State Zip Code

_____

Home Telephone Number Mobile Phone Number Email Address

_____

Marital Status Employer Name and Address Work Phone Number

PATIENT INFORMATION:

_____

Last Name First Name Middle Name

_____

Date of Birth Social Security Number Gender

_____

Street Address OR PO Box Number City State Zip Code

_____

Home Telephone Number Mobile Phone Number Email Address

_____

Marital Status Employer Name and Address Work Phone Number

Is this visit work-related? Circle YES or NO If yes, list the date the injury occurred_____

Briefly describe how the accident occurred. _____

_____

EMERGENCY CONTACT INFORMATION: (Please list someone who does NOT live in the same household)

_____

Last Name First Name Middle Name

_____

Street Address OR PO Box Number City State Zip Code

_____

Home Telephone Number Mobile Phone Number Work Phone Number

INSURANCE CARRIER: **A COPY OF INSURANCE CARD IS ALSO REQUIRED**

_____

Insurance Company Name & Address

_____

Telephone Number | Group Name or Number | Member ID Number

_____

Name of Insured | Insured's Date of Birth

_____

Insured's Social Security Number | Insured's Employer

_____

Patient's Relationship to Insured

SECONDARY INSURANCE CARRIER:

_____

Insurance Company Name & Address

_____

Telephone Number | Group Name or Number | Member ID Number

_____

Name of Insured | Insured's Date of Birth

_____

Insured's Social Security Number | Insured's Employer

_____

Patient's Relationship to Insured

AUTHORIZATION:

I hereby authorize Dr. Kevin McAlpin's office to furnish information to Insurance Carriers concerning my medical care and claims.

X_____

Responsible Party Signature

DATE ENTERED INTO SYSTEM_____ By:_____

Kevin McAlpin, D.C.

MEDICAL HISTORY

Date: _____

Name:_____

Medications:_____

Medication Allergies:_____

Family History of Diabetes? **Y** **N** Early Heart Disease? **Y** **N**

TB? **Y** **N** Cancer? **Y** **N**

Tobacco Use?_____ Alcohol?_____ Drugs?_____

Ob/Gyn History:_____

Medical History:_____

Trauma History:_____

Surgery History:_____

Other Hospitalizations:_____

	YES	NO		YES	NO
Weight fluctuation……	( )	( )	Heart Attacks……	( )	( )
Poor Appetite……	( )	( )	Chest Pain…..……	( )	( )
Hearing Loss……	( )	( )	Hypertension……..……	( )	( )
Poor Strength……	( )	( )	Palpatations……	( )	( )
Blackouts……	( )	( )	Chronic Cough……	( )	( )
Chronic Headache……	( )	( )	Asthma……	( )	( )
Thyroid Trouble……	( )	( )	Diarrhea……	( )	( )
Food Intolerance……	( )	( )	Constipation……	( )	( )
Ulcers……	( )	( )	Change in Bowel Habits….	( )	( )
Gall Bladder Disease……	( )	( )	Blood in Stool……	( )	( )
Indigestion……	( )	( )	Hernia……	( )	( )
Swelling of legs……	( )	( )	Frequent Urination……	( )	( )
Cramping of legs……	( )	( )	Pain During Urination……	( )	( )
Arthritis……	( )	( )	Poor Circulation……	( )	( )
Pace Maker……	( )	( )	Emotional Disorder……	( )	( )
Possibly Pregnant……	( )	( )	Metal Srews or Implants…	( )	( )
Pregnant……	( )	( )			

Remarks:_____

_____

Kevin McAlpin, D.C., P.A. License # 6311

Occupational Medicine
Designated / Required / Independent Medical Examiner
Impairment / Functional Evaluations

3802 21st Street, Ste A Lubbock, TX 79410 Office 806.722.4190 Fax 806.722.4192

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if anything is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sensation of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

_X_spinal manipulative	___palpation	___vital signs
___ range of motion testing	___orthopedic testing	___basic neurological testing
___muscle strength testing	___postural analysis	_X_EMS
___ultrasound	___myofacial release	_X_hot/cold therapy
___radiographic studies	___ Other (please explain)	

_____

_____

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The Risks and Danger Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Kevin McAlpin, D.C. 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 have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____ **Date:_____**

_____ **_____**

Patient's Name **Doctor's Name**

_____ **_____**

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)