EASTSIDE CHIROPRACTIC, P.C.
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DR. BRYAN HOOPER
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HEALTH HISTORY, PART 2

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bulimia
- ☐ Chemical dependency
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated disc
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Mental health problems
- ☐ Methamphetamine use/exposure
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Pinched nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis
- ☐ Scarlet fever
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease
- ☐ Whooping cough
- ☐ Other: _____

INFORMED CONSENT

Chiropractic, as well as with other types of health care, is associated with potential risks in the delivery of treatment, though rare. Therefore, it is necessary to inform the patient of such risks prior to initiating care. Some risks include: fractures, disc injuries, strokes, dislocations, 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have had an opportunity to discuss with a doctor or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions of the doctor (or staff) about this content. By signing below, I hereby authorize the physicians and staff at Eastside Chiropractic to treat my condition as deemed appropriate. I certify that the above information is correct to the best of my knowledge. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment from the doctors at Eastside Chiropractic, PC.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic at Eastside Chiropractic, PC.

_____ _____

Patient's signature (or legal guardian if minor) **Date**