PATIENT INTRODUCTION FORM (Cash Patients)
HOKOKIAN CHIROPRACTIC

1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

Today's Date: _____

Last Name:		**MI:** **First Name:**	
Home Address:		**City:** **State:** **Zip:**	
Date Birth:	Age:	Telephone: **Home:**	**Cell:**
Height:	Weight:	**Business:**	
Employer's Name:		Social Security/ID Number:	
Occupation:		Marital Status (Circle): Single, Married, Divorced, Widowed	
Referred By:		Name of Family Physician:	
Email Address:			

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

Welcome to our office. For cash patients it is important that you understand our office financial policies. It is our policy to provide the best care possible for your condition(s). Charges for any history, examination, x-rays, supplies, and services-treatments are due at the time of the visit. Our office takes Visa/MasterCard payments.

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY. WE CAN EASILY PROVIDE THE PATIENT WITH A SUPERBILL THAT HAS A BILLING STATEMENT FOR EACH OFFICE VISIT. THIS BILLING STATEMENT WILL HAVE ALL OF THE NECESSARY INFORMATION FOR THE PATIENT TO SUBMIT TO THEIR INSURANCE CARRIER. HOWEVER, INORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS. ANY OUTSTANDING BALANCE CAN BE SUBJECT TO AN 18% ANNUALLY OR 1 ½% PER MONTH INTEREST.

If unable to pay for the treatment or other costs please ask to speak to the office manager to make financial arrangements. If you choose to terminate care at this office the outstanding balance is immediately due and payable. Please sign below acknowledging your responsibility for payment for services.

Patient Signature and Date:	I am a responsible party and agree to pay for any outstanding bills incurred in this office.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with patient privacy and security laws (45 CFR 160,164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how my protected health information (PHI) may be used and what their office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall.

☐ **LEGAL GUARDIAN/PARENT NAME/RELATIONSHIP:** _____

Patient Name: Date:

GENERAL HEALTH HISTORY (Page 1)

HOKOKIAN CHIROPRACTIC

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DESCRIBE THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury). Print Clearly

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine-metabolic disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of infectious diseases such as AIDS, Tuberculosis, Meningitis, Hepatitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	Cancer history or cancer treatment or surgery of any type?	☐	☐
☐	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal or brain aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

If you checked yes, please describe:

☐ No, ☐ Yes Do **you have an infection, cold, virus, or other recent illness? Describe: _____**

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

☐ **NO. (Check box if you have no prior history of previous injury or pain)** If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO. (Check box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES? ☐ NO. (Check box if you never had any surgical procedure).
If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

Patient Name:
Date:

GENERAL HEALTH HISTORY (Page 2)
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☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, or other diseases?

If yes, please describe:

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City: _____ Year:_____
List Problem(s) that the Chiropractor treated you for: _____
_____

Indicate when you have your last physical examination by a medical doctor and please indicate his/her name?	Doctor: Date:

☐ No, ☐ Yes Do **you have any problems laying face down on an examination table** (tender breasts, chest or breast surgical implants, ports, etc? If yes, why: _____

MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

☐ No, ☐ Yes **Are you taking any medications currently?** In yes, list all medications that you are taking:

☐ No, ☐ Yes**. Have you taken any pain medications today? If yes, describe: _____**

FOOD OR MEDICATION ALLERGY HISTORY

☐ No, ☐ Yes. Do you have allergies to any medications, foods, shellfish, seafood, etc? If yes, List:

DESCRIBE YOUR TYPICAL EXERCISE ROUTINE CURRENTLY

Describe what types of exercise you perform:	
How often to do you regularly exercise?	

SYMPTOM OR COMPLAINT ONSET

☐ Suddenly, ☐ Gradually. Check box indicating if your current symptoms developed gradually or suddenly.

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

YES	NO	SLEEPING PATTERNS
☐	☐	Do you sleep poorly at night?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you consistently feel extremely tired when you wake up in the morning?

Patient Name: Date:

NECK, BACK, SACRUM, PELVIS PAIN AND/OR INJURY HISTORY (Page 3)

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Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES	NO	GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)
☐	☐	Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
☐	☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?
☐	☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
☐	☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
☐	☐	Have you had a previous head injury in the past (e.g., blow or fall)?
☐	☐	Have you injured your neck, back, sacrum or pelvis in the past?
☐	☐	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
☐	☐	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

NECK PAIN AND/OR INJURY HISTORY

Describe your neck pain location (left side, right side, middle of your neck or on both sides).	
When did your neck pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any neck injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your neck or referring arm pain worse?	
Describe any relieving physical activities. What activities lessen your neck/arm symptoms?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands.	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your neck before.	

YES	NO	NECK REGION HISTORY CONTINUED
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out, lose your balance or get a headache when you look up or twist your head?
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders or to the front of your chest?
☐	☐	Have you had a new type of headache or an unusually severe headache recently?
☐	☐	Have you noticed your head leaning or tilting to one side recently?

Patient Name:

THORACIC, LUMBAR, SACRUM, PELVIS REGION HISTORY (Page 4)

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Describe your pain location (middle back, lower back, sacrum and if located in the front/side/back of body)	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your back or referring leg pain worse?	
Describe any relieving physical activities. What activities lessen your back or leg symptoms?	
Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your back before.	

YES	NO	THORACIC AND LOW BACK REGION HISTORY CONTINUED
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Do you have a tight band-like feeling sometimes around your chest?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distance that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Do you have a lot of leg cramps at night recently?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Has your anal-rectal region been completely numb?

If yes, describe and indicate dates:

Patient Name:
Date:

Form 1010

EXTREMITY PAIN OR INJURY QUESTIONNAIRE

HOKOKIAN CHIROPRACTIC

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Please answer the following sections that apply to you.

SHOULDER, ARM, ELBOW, WRIST AND HAND REGION

Describe pain location (left, right, middle, front, and back, top). Example: top of shoulder joint/inside left elbow)	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your shoulder-arm symptoms worse?	
Describe any relieving physical activities/motions. What lessens your shoulder-arm pain-symptoms?	
If present, describe which fingers or part of your hand you have any pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your shoulder, arm, or hands before.	

HIP, LEG, KNEE, ANKLE AND FOOT REGION

Describe your pain location (left, right, middle, front, back). Example: front of hip/outer calf area.	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened)?	
Describe all aggravating physical activities/motions: What makes your hip-leg pain-symptoms worse?	
Describe any relieving physical activities: What lessens your hip-leg symptoms-pain?	
If present, describe which toes or part of your leg/foot you have any pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your hip, leg, knee, ankle, and foot before.	

Patient Name:
Date:

HEADACHE-MIGRAINE QUESTIONNAIRE

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Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

1. If your headaches/migraines have begun recently, can you think of some event or cause that may have started your pain? ☐ YES, ☐ NO If yes, what: _____

2. If your headaches/migraines have been bothering you for more than six months, can you describe what you think is causing them or making them worse? ☐ YES, ☐ NO If yes, describe: _____

_____

3. Circle how intense your typical headaches/migraines are recently? (Use 0-10 intensity)

Pain Intensity	None	Mild Discomfort/Annoyance	Moderate Hurts/Sore/Bearable Sensation	Severe Sharp/Intense/Unbearable

Headache (circle)	0	1	2	3	4	5	6	7	8	9	10

4. Recently, would you describe the frequency and severity of your headaches-migraines as being the same as usual, a little worse than usual, or a type of headache that is entirely new/unusual: _____

5. WHEN DO YOU USUALLY GET YOUR HEADACHES-MIGRAINES?

☐	Morning	☐	End of week	☐	After napping or oversleeping
☐	Afternoon	☐	Bright light causes them	☐	After drinking alcohol
☐	Evening	☐	During or after having sex	☐	Before menstrual cycle
☐	During sleep	☐	During emotional stress	☐	During menstrual cycle
☐	During weekends	☐	After emotional stress	☐	After menstrual cycle
☐	Beginning of week	☐	During physical exertion	☐	After bending your head downwards
☐	Middle of week	☐	After not eating several hours	☐	No pattern

6. WHAT USUALLY HELPS YOUR HEADACHES-MIGRAINES?

☐	Sleeping	☐	Improving posture	☐	Drinking coffee
☐	Rest	☐	Dark quiet room	☐	Muscle massage
☐	Eating	☐	Medications	☐	Cold packs
☐	Spinal adjustments	☐	Nothing helps	☐	Other:

7. DESCRIBE HOW YOUR HEADACHE-MIGRAINE USUALLY FEELS:

☐	Pounding	☐	Burning	☐	Pressure
☐	Constant pain	☐	Aching	☐	Exploding
☐	Throbbing *	☐	Sharp-Piercing	☐	Dullness

8. WHERE DOES MOST OF YOUR HEADACHE PAIN FOCUS? (Check all that apply)

☐	Entire head area	☐	Front of head	☐	Left side of head
☐	Back of head near neck area	☐	Eye region	☐	Right side of head
☐	Top of head	☐	No pattern	☐	Both sides of head

9. IF YOUR HEAD PAIN RADIATES, WHERE DO YOUR HEADAHCE-MIGRAINES START?

☐	Neck area	☐	Front of head	☐	Near eyes
☐	Back of head	☐	Side of head	☐	Other:

Patient Name:
Date:

HEADACHE-MIGRAINE FORM (Page 2)
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Recently, how many headaches/migraines do you usually have in a month? ____ Times a month
Recently, how many hours does a typical headache/migraine last for you? ____ Hours
On average, how many pills do you take every month for headaches? ____ Number pills per month

10. ☐ YES, ☐ NO Have you seen other Doctors for your headaches-migraines? Please list and describe treatment and if it helped. Also indicate if you have had any brain scans, laboratory tests, or other diagnostic tests done to evaluate your headaches. _____

_____

What have your previous doctors told you were the cause(s) for your headaches?

11. MEDICATIONS: *Please write in all medications that you have taken recently for any condition.*

12. HEADACHE-MIGRAINE HISTORY (Check any of the following that apply to you):

☐	Family history of headaches or migraines
☐	History of motion sickness as a child
☐	Headaches-migraines associated with shortness of breath or excessive exhaustion
☐	Headaches-migraines associated with numbness of face and/or tongue
☐	Headaches-migraines associated with arm or leg weakness
☐	You usually know your headache is starting soon by various symptoms such as visual or sensory feelings
☐	You see lights/spots in your vision 5-50 minutes before headache-migraine pain begins
☐	You are very sensitive to light or sound during or after headache-migraine
☐	You presently or recently had a fever. This fever began just before your headaches started or during headache.
☐	You had a rash, chills, fever, headache, and joint pain/swelling 2 weeks prior to your headaches starting.
☐	Physical exertion makes your headache-migraine worse (climbing stairs, sex, lifting, etc)
☐	Headaches start 3-4 hours after eating and/or your headaches improve after you eat
☐	Jaw pain before or during headache
☐	Muscles in neck and shoulders are tight/stiff or sore prior to headache
☐	Headaches-migraines get worse when you have sustained poor posture
☐	Headaches-migraines begin or get worse when you rotate or twist your head and/or neck
☐	You get dizzy or black out when headaches-migraines occur
☐	Get tearing, face flushing, or nasal discharge during headache-migraine
☐	History of sinus infection, allergies, deviated septum, or other nasal disorders
☐	You bruise easily, sometimes finding bruises on your thighs or legs and you can't recall any injury to your leg.
☐	History of neck or head injury
☐	You eat or drink substances having caffeine (coffee, chocolate, or tea). I drink _____ number of cups per day.
☐	Your body usually feels cold
☐	Thyroid problems currently or in past
☐	You do not feel rested after sleeping

Patient Name:
Date:

SYMPTOM INTENSITY AND FREQUENCY FORM
HOKOKIAN CHIROPRACTIC

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PATIENT: _____ DATE: _____

For SECTION 1, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels currently present. A zero (0) indicates that no symptoms exist. 1-3 pain level is a minimum level and indicates that your pain is an annoyance only. A 4 pain is a slight level or where pain doing an activity begins to cause some disability. A 5-7 pain is moderate in severity and has to restrict or limit your activity ability to a significant degree. An 8-10 pain level is severe and indicates that your pain intensity is to the point where you have complete inability to perform some tasks. For SECTION 2, describe how frequently you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	**MINIMAL** Discomfort/Ache/Stiff			**SLIGHT-TO-MODERATE** Hurts/Sore/Bearable Sensation			**SEVERE** Sharp/Intense Pain			
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional			Intermittent			Frequent			Constant
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 3. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches/migraines?

- ☐ No headaches
- ☐ 1-2 times a month
- ☐ 3-4 times a month
- ☐ Once a week
- ☐ 2-3 times a week
- ☐ 4-5 times a week
- ☐ Almost daily
- ☐ Daily
- ☐ All the time

B. How many hours does your typical headache/migraine last? _____ Hours?

Patient Name:
Date:

PAIN INTENSITY INSTRUCTION FORM
HOKOKIAN CHIROPRACTIC

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PATIENT: *Be certain to read the following pain categories and indicate which level best represents how severe your current pain level is relative to your ability to perform activity. If you do not understand these instructions be sure to ask the Doctor.*

Pain Intensity	None	**MILD**			**MODERATE**				**SEVERE**		
PAIN LEVEL	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

PAIN LEVEL AND THE EFFECT THAT PAIN HAS ON YOUR ABILITY TO PERFORM ACTIVITY	No Pain	Annoying Pain Level Only. Able to Perform All Home, Work, Sport, and Recreational Activities. No Restrictions	Pain Levels Now Cause You to Slow Down. You Are Able to Do Activities at Home and Work, But They Take You Longer to Do or You Need to Take Breaks. Unable to Do More Demanding Activities.	Pain Levels Must Prohibit Your Ability to Perform Several Activities. You Must have Some Inability to Do Easier Activities. Must Have Some Difficulty Sleeping.
HOW DOES THE PAIN FEEL?	No Pain	Ache, Dull Soreness, Stiffness	Hurting Pain, Very Sore, Limited Motion	Sharp Pain, Stabbing Pain, Jabbing Pain
LEVEL	****	MILD	MODERATE	SEVERE

A LEVEL 10 PAIN IS UBEARABLE AND IS SIMILAR TO THE MOST SEVERE PAIN YOU HAVE EVER HAD!

A 10 level pain is unbearable and equates to having the most severe pain you have ever had, such as a toothache, burn, or kidney stone type of pain!

Patient Name:
Date:

INFORMED CONSENT
HOKOKIAN CHIROPRACTIC

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I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient names below, for whom I am legally responsible) by **Dr. John H. Hokokian, D.C.,** and/or other licensed doctors of the chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Dr. John H. Hokokian, D.C.,** whether or not their names are listed on this form.

I understand and consent to the following procedures (checked below):

☐ Examination ☐ Mobilization ☐ Ultrasound ☐ Muscle Stimulation
☐ X-rays ☐ Traction ☐ Adjustments

I have had an opportunity to discuss with **Dr. John H. Hokokian, D.C.,** the various types of treatment, including neck and spinal/extremity adjustments that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT) _____DATE:_____

X_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

(If signing for a MINOR)
NAME: _____RELATIONSHIP:_____

OFFICE/WITNESS SIGNATURE: _____ DATE: _____

Patient Name:
Date: