

# Zelasko Chiropractic

## Confidential Patient Case History

### Personal Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ Sex: Male / Female Marital Status: M S W D  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Referred by \_\_\_\_\_

### Work Information

Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emp. Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emp. Phone \_\_\_\_\_ Emp. Status \_\_\_\_\_

### Health Information

Have you had previous Chiropractic Care? Yes / No  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
What is your chief complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Medications \_\_\_\_\_

**Informed Consent:** I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Zelasko. I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, sprains. I do not expect Dr. Zelasko to be able to anticipate or explain all risks and complications, and I wish to rely on Dr. Zelasko's judgement during the course of the procedure which Dr. Zelasko feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me and understand the above consent. By signing below I agree to the abovementioned procedures. I intend this consent form to cover the entire course of treatment for my present condition. I understand that payment is due at the time care is rendered and that no private insurance is accepted.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian / Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_