Wehrspan Chiropractic | 924 4th St. West Des Moines, IA 50265 | 515.224.9999

Welcome!

The staff of Wehrspan Chiropractic is pleased to welcome you to our clinic. Please fill out this form as completely as you can. We look forward to helping you feel and function at your best!

Patient Information

First Name_____ Last Name_____

Birth Date_____ Mobile Phone_____

Gender_____ Email_____

Address_____

City_____ State_____ Zip_____

Emergency Contact Name_____ Relationship_____

Emergency Contact Phone_____

Patient Employment_____

How Were You Referred to Us_____

Insurance Information

Insurance Company_____

Insurance ID#_____ Group#_____

Insured's Name_____

Insured's Birth Date_____ Insured's Phone_____

Insured's Gender_____ Relationship to Patient_____

Insured's Address_____

A copy of your insurance card must be obtained by our staff

Acceptance as Patient

I understand that I am financially responsible for all charges, whether or not paid by insurance, for any services rendered on my behalf. This includes services that may not be a covered benefit under my insurance plan or any services they may deem not medically necessary. Any quote of my insurance benefits given to me by the staff of Wehrspan Chiropractic is given to them by my insurance company and is not a guarantee of these benefits. Also, I acknowledge I have had access to the Notice of Privacy Practices of Wehrspan Chiropractic and reviewed these if I so desired.

Patient Signature_____ **Date**_____

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Reason for Visit

Describe Complaints_____

_____

_____

_____

Onset Date_____ Pain Intensity (1 to 10)_____

Cause_____

Frequency_____

Quality: ☐ Aching ☐ Throbbing ☐ Burning ☐ Sharp ☐ Tingling ☐ Stiff ☐ Dull ☐ Numb

Worse with_____

Better with_____

Treatment for Current Complaint_____

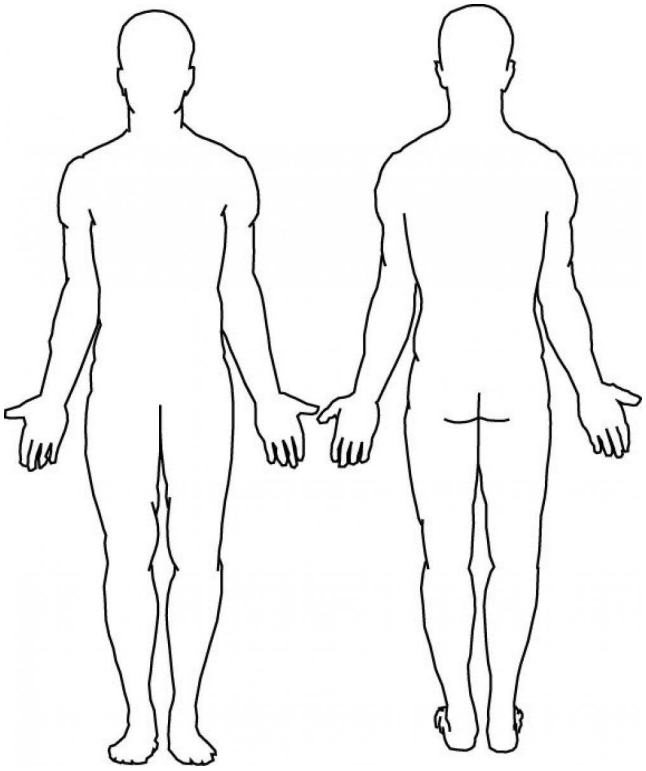
_____

Any Previous Chiropractic Care (Who & When)

_____

_____

Mark on diagram anywhere you have pain →



Your Health History

(Do not include Family History)

☐ Cancer	☐ Stroke
☐ Cholesterol	☐ Blood Pressure
☐ Diabetes	☐ Dizziness/Vertigo
☐ Pregnant	☐ Heart Attack
☐ Osteoporosis	☐ Osteopenia
☐ Arthritis	☐ Rheumatoid
☐ Thyroid	☐ Artificial Joint
☐ Neck Pain	☐ Headaches
☐ Low Back Pain	☐ Herniated Disc
☐ Foot Pain	☐ Hip/Leg Pain
☐ Wrist Pain	☐ Shoulder/Arm Pain
☐ Hyperflexible	☐ Bruising
☐ Seizures	☐ Fainting/Light Headed

Diseases, Accidents, Broken Bones, Surgeries (With Dates)_____

_____

Medications and Reason for Taking_____

_____

Doctors Being Seen and Why_____

_____

Patient Name_____ **Date**_____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Please read this entire document prior to your evaluation by Dr. Wehrspan. It is important that you understand the information contained in this document. **DO NOT SIGN UNTIL AFTER DR. WEHRSPAN EVALUATES YOU** and discusses this information with you. Please ask Dr. Wehrspan questions if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by a Doctor of Chiropractic is spinal and extremity manipulative therapy. The Doctor will use that procedure to treat you. The Doctor may use his 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," and you may feel a sense of movement. As a part of the analysis, examination, and treatment, you are consenting to spinal and extremity manipulative therapy, palpation, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, and physiotherapy procedures.

The risks inherent in the 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 strains, spinal cord or other nerve injuries, rib injuries, 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. The Doctor 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 the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke. 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-inflammatories, muscle relaxants and pain-killers; Physical Therapy; Hospitalization; Surgery. If you choose to use any of these 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 medical physician.

The risks and dangers attendant to remaining untreated. Potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. This may complicate treatment making future recovery and rehabilitation more difficult and lengthier.

Consent to Treat Minor. As of this date, I have the legal right to select and authorize health care services for the minor to be treated and hereby request and authorize Dr. Kirk L. Wehrspan to render him/her chiropractic evaluation and treatment.

DO NOT SIGN UNTIL YOU HAVE READ, DISCUSSED WITH THE DOCTOR, AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kirk L. Wehrspan 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. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Date: _____ Date: _____

Patient Name: _____ Doctor Name: Kirk L. Wehrspan, DC, CCEP

Patient (Parent) Signature: _____ Doctor Signature: _____