HELM FAMILY CHIROPRACTIC & WELLNESS, P.L.L.C.
2106 Avenue E, Hondo, TX 78861, 210-859-0808

Confidential Health History

Name: _____ Date: _____

First Name Last Name

Address: _____

Street City State Zip

Cell Phone: _____ Secondary Phone: _____

Date of Birth: _____ /_____ /_____ Height: _____ Weight: _____

Occupation: _____ Email Address: _____

We respect your privacy and do not sell email addresses.

Reason for office visit:	Date began:	Pain Scale 1 – 10:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Treatments:

_____

Have you ever had chiropractic treatments in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Major Hospitalizations, Surgeries, Injuries:

Year	Surgery, Illness, Injury
_____	_____
_____	_____
_____	_____

Do you currently have any of the following condition? Please circle all that apply.

Migraine headaches	Chronic fatigue syndrome	Low Back Pain	Arthritis
Headaches	Carpal Tunnel Syndrome	Stroke	Other _____
Osteoporosis	Blood Pressure Problems	Fibromyalgia	_____

Medications: Please circle all that you are currently taking.

Antacids	Steroids (prednisone)	Cardiac/Heart Medication	Antihistamines
Pain Killers	Birth Control Pills	Blood Pressure Medication	Hormones (estrogen, progesterone, DHEA, Parasite Medication, testosterone, thyroid)
Antibiotics	Anti-inflammatory	Yeast/Fungal Medications	
Diuretics	Muscle Relaxers	Antidepressants	

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and soft tissue procedures on me (or the patient name below, for whom I am legally responsible) by Helm Family Chiropractic and Wellness PL.L.C.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks inherent in treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains.

PLEASE NOTE: Dr. Helm is a third generation chiropractor. While these risks remain a possibility, to our knowledge we have never had a patient suffer any of these complications.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above- named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that Helm Family Chiropractic and Wellness P.L.L.C. does not accept insurance, nor do they file any paperwork to institutions on my behalf.

To be completed by the patient

_____

Print Patient Name

_____

Signature of Patient

_____

Date Signed

To be completed by patient's representative, if necessary. For example, if a patient is a minor or physically or legally incapacitated.

_____

Print Patient Name

_____

Print Name of Patient's Representative

_____

Signature of Patient's Representative

As: _____

Relationship or Authority of Patient's Representative

_____

Date Signed