

Murphy Chiropractic & Performance Center  
1633 Northwest Blvd. Columbus, OH 43212  
(614) 488-1633

**PATIENT ENTRANCE FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE# \_\_\_\_\_

**PRIOR CHIROPRACTIC CARE**

NAME \_\_\_\_\_ LOCATION \_\_\_\_\_

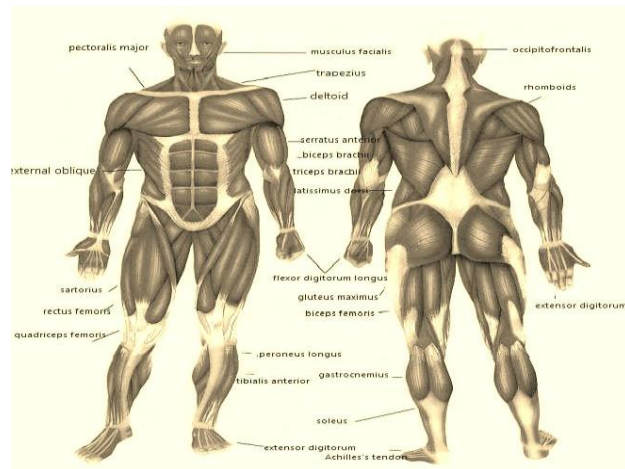
MOST RECENT VISIT \_\_\_\_\_ XRAYs TAKEN YES / NO DATE \_\_\_\_\_

MEDICAL DOCTOR NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

REFERRED BY \_\_\_\_\_

USING THE CHART BELOW, PLEASE MARK YOUR SYMPTOMS ACCORDING TO LOCATION AND TYPE OF PAIN/DISCOMFORT: NUMBNESS ==, BURNING XXX, PINS/NEEDLES +++, DULL ACHE OOO, SHARP/STABBING ///, OTHER >>>



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## INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible.)

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. In chiropractic, these risks include but are not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I 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, is in my best interests.

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

### TO BE COMPLETED BY PATIENT

Patient Name \_\_\_\_\_ (Please Print)

Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_

### TO BE COMPLETED BY PATIENTS REPRESENTATIVE IF PATIENT IS A MINOR

Name of Representative \_\_\_\_\_ (Please Print)

Signature of Representative \_\_\_\_\_

Date Signed \_\_\_\_\_

Relationship of Authority of Patient's Representative \_\_\_\_\_