## PATIENT INFORMATION

		. i				Ander Street, Land
First Name	M.I	Last Name		Date	. 1	
Date of Birth						L
Weight					100	0
Address						
Home Phone						
Email		Social Security	y #			Minternas
Employer Name		Job Title	e		-	****
Spouse's Name Spouse Da			e of Birth			-
Person Responsible for this ac	count					
Health Insurance Company	A PROPERTY OF THE PROPERTY OF		STATE OF THE PARTY	Land to the second second		
Policy/Member ID#		Grou	# aı	Management and state of the Park of Spanning Spa		-
Address						
Phone #	Name of the Insuran	ice Card Holder	***************************************			-
Social Security # of card holde	r			The second		Received to the
Name of their employer						
Children Name and ages						processors.
In case of emergency, who sh	ould we contact?		Phone	e #	gant hanga qar gan ligi ta da risaan qanga a	Martin de Albary
Family Physician		Phone #				
Address	C	City	State	Zip Code		MARKAGO CO.
Na 6 at - 1						- Indiana
Name of the insured	And the second s					
I understand and agree that health/ agree that all services rendered t terminate care/ treatr	/accident insurance policies ar to me and charged are my per ment, any fees for professiona	Sonal responsibility for the	make naumant 1.	and the test of the second	rstand a pend or	nd
Patient's Signature						
Spouse's or Guardian's Signat	ure		Date	A		-
					M-100-00-00-00-00-00-00-00-00-00-00-00-00	-

Medical History			
Have you been treated for any condition	ons in the last year? () N	o O Yes	
) os biogse describe	THE SECOND PROPERTY OF THE PARTY OF THE PART	C 162	
Date of last physical exam	Ils there a chan	20 the art	The state of the s
Have you had X-rays taken? O No C	Yes If Yes, where	ce that you are pregnant? O	Vo O Yes
What medications are you taking and for	Yes If Yes, where?	Annual services and the services are the services and the services and the services and the services and the services are the	And the same of th
What medications are you taking and fo	of what conditions (Please	e list dosage and amounts, etc	THE RESERVE CO. LANSING MICH. P. LANSING MICH.
1			the second section of the second section of the second section of the second section s
What vitamins, minerals, or herbs do you	Currently takes (Please li	A L	
What vitamins, minerals, or herbs do you	man in the second secon	st for what conditions, dosage,	and frequency).
and the American Confession of the Confession of	and the particular and the parti		
HCVO VAIV			Control Season A. Stay and College in the College i
Have you ever: Broken bones?	No Yes	Briefly Explain	
Been hospitalized?	00	Annabian of the second determinant	4 - Marie Carlotte Ca
Been in an auto accident?	100	AND ADDRESS OF THE PARTY OF THE	
dad Sprains/Strains?	QÕ	THE RESERVE OF THE PROPERTY OF	AND THE COURSE BUT SEE SEE STATE OF STATE AND ADDRESS OF THE SECTION OF THE SECTI
een struck unconscious?	00000	The state of the s	のでは、またい。 は、これでは、これでは、これでは、これでは、これでは、これでは、これでは、これで
lad surgery?	100	THE RESIDENCE OF THE PROPERTY OF THE PARTY O	THE RESERVE THE PROPERTY OF TH
	00	Chromator by the register was made in a construction of the constr	CONTRACTOR OF THE SECURITY OF
April 6 Mars			THE RESERVE OF THE PROPERTY OF
amily History: amily Members - Present and past h		AT A PROPERTY OF THE SECONDARY	College and Proceedings
o you experience pain every day? o your symptoms interfere with daily oes pain wake you up at night? re your symptoms worse during certo o changes in weather affect your sy			O No O Yes O No O Yes O No O Yes
a ) a wedi officia	mptoms?		ONO OYes
you take vitamin supplements			O No O Yes
nat activities aggravate your sympt	oms?		O No O Yes
- Hallman Carrier	CONTRACTOR STATEMENT OF THE PROPERTY OF THE PR		O No O Yes
	at .		
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Drinks		8 8	8 8
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Have you ever suffered from:	
LIAICONOIISM	Please use the following that
Allergies	Please use the following letters to indicate TYPE and
Anemia	LOCATION of the symptoms you currently are experiencing.
Arteriosclerosis	l la
Arthritis	A=Ache O=Other
Asthma	B=Burning P=Pins & Noodles
Back Pain	
Bro det Lucia	N=Numbness S=Stabbing
Breast Lump	
Bronchitis	Const.
Bruise Easily	
Cancer	
Chest Pain/Conditions	
Cold Extremities	
Constipation	
Cramps	
Come	
Depression	
Diabetes	
Digestion Problems	MI RETSHAM WAS INVESTED AND A MANAGEMENT OF THE PROPERTY OF TH
Dizziness	
Ears Ring	
Excessive Menstruation	
Eye Pain or Difficulties	
Fatigue	
Frequent Urination	
Headache	
Hemorrhoids	
Hernormolds	
High Blood Pressure	
Hot Flashes	
megular Heart Beat	
megular Cycle	
Kidney Infection	
Kidney Stones	
Loss of memory	
Loss of balance	
Loss of smell	
Loss of taste	<b>9 (3</b>
umps in Breast	
Neck Pain or Stiffness	
Nervousness	
Nosebleeds	
Polio	
Poor Posture	
Prostate Trouble	The state of the s
Sciatica	
Shortness of breath	WYX PROPERTY OF THE PROPERTY O
Sinus Infection	
Sleep problems or Insomnia	
ppinal Curvatures	
Stroke	
Swelling of ankles	
Swollen Joints	
Thyroid Constitution	3
Thyroid Condition	
Tuberculosis	
Ulcers	
Varicose Veins	
Venereal Disease	
Other:	

## Patricia A. Wendel, D.C.

222 Carter Drive, Suite 103 Middletown, DE 19709 Phone: 302-593-0031

2005 Concord Pike Suite 202 Wilmington, DE 19803

## Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to: ☐ Broken bones increased symptoms and pain Dislocations ☐ No improvement of symptoms or pain ☐ Sprains/strains ☐ Infection (acupuncture) ☐ Burns or frostbite (physical therapy) ☐ Punctured lung (acupuncture) ☐ Worsening/aggravation of spinal conditions Other In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. TREATMENT PLAN: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition. *To be completed by the patient:* To be completed by the patient's representative: print name print name of patient signature of patient print name of patient's representative date signed signature of patient's representative relationship/authority of patient's representative date signed To be completed by doctor or staff: witness to patient's signature date translated by date Revised May 2017