Coastal Chiropractic
Massage Patient Application

Please fill out form in its entirety

Today's Date _____

Name _____ SS# _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Preferred # to Call: Home / Cell

Birth Date ___ /____ /_____

Who may we thank for referring you? _____ Relationship _____

My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement. I understand that if the doctor believes I may benefit from Chiropractic care I will then proceed with the examination process. I understand and, am informed, that while extremely rare there are some risks to treatment including but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. It is important that our patients share our same health objectives concerning chiropractic care. Regardless of what disease or condition is called, we do not offer to treat it. Our only practice is to eliminate a major interference to the expression of the body's innate intelligence. Our specific method of correction is adjusting subluxations. We believe the greatest doctor is the one already inside each of our patients and we seek to help maximize this inherent healing power without drugs or surgery. Your signature verifies that the information given is complete and correct ant that you accept, if eligible, chiropractic care on that basis.

_____

Patient Signature *Date*