DR. ROBERT S. DERRYBERRY, D. C.

Chiropractic ~ Clinical Nutrition/Functional Medicine ~ Nutritional Supplements
513 13th Street, Paso Robles, CA 93446   Office, (805)239-4077
Fax: (805)239-4076   Email: drd@drderryberry.com

NEW PATIENT HISTORY

Last Name ______ First Name ______ Today's Date ______ Case No. ______

Street ______ Home Phone ______

Cell Phone ______

City ______ State ______ Zip ______ Email address ______

Age ______ Birth Date ______ Marital: M S W D Children: Name/Age ______

Occupation ______ Employer: ______ Work Phone ______

Name of Spouse ______ Spouse's Occupation ______

Spouse's Employer ______ Spouse's Work Phone ______

Referred by ______ Date of Last Physical Exam ______ Currently Pregnant Yes No

What Operations Have You Had & When ______

Serious Illnesses & When ______

What Are You Currently Suffering From: (ex: Headaches, Back Pain, Indigestion, Fatigue, Allergies)

1. ______ 6. ______
2. ______ 7. ______
3. ______ 8. ______
4. ______ 9. ______
5. ______ 10. ______

Purpose of this Appointment ______

Other doctors seen for this condition? Yes ______ No ______

Dr's Names Have you been treated for any health condition by a doctor in the past 12 months? ______

Yes ______ No ______

If yes describe: ______

What Medication Are You Taking? ______

What Vitamins Are You Taking? ______

Payment is expected at time of visit. Patients who carry health care insurance should remember that professional services are rendered and charged to the patient and not the insurance company.

Name of person responsible for payment ______

Patient's Signature ______ Soc Sec # ______ Date ______

Information Taken By ______ Date ______

DRD 000

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Please read, sign and date.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examination, chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, diagnostic x-rays, tests performed to assess nutritional status on me(or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the office listed below or any other office, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with office personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure, I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but limited to: disc injuries, dislocations, fractures, soft tissue injuries, sprains and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options may include, but not limited to: self-administered; over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; surgery and other modalities.

I have read or have had read to me and understand the foregoing. 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 this consent from to cover the entire course of treatment for my present condtion and for any future condition(s) for which I seek treatment.

Date ______________________

Patient Name(printed) ______________________________________

Signature ____

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INFORMED CONSENT

This is to acknowledge that I am in full agreement with Applied Kinesiology and Reflex Analysis, which are simple, natural methods of analyzing the body's structural, physical and nutritional needs. I am aware that a deficiency in any of these areas could cause or contribute to various health problems.

I also understand that conditions of Cancer, Venereal Disease, AIDS or any other Communicable diseases, are not being treated.

No promise or guarantee has been made regarding the results of treatment which I understand is not for a disease, but rather, it is a means by which the body's reflexes are used to determine the root cause of nutritional imbalances.

I have read, and understand the foregoing.

Signature ______________________________

Date ______________

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