

This Notice is in effect as of 4/14/2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that i was provided a copy of the Notice of Privacy Practices and that I have read it, or declined the opportunity to read it, and understand the Notice of Privacy Practices contains the privacy policies of Cooper Chiropractic Center. I understand that this form will be placed in my patient file and maintained for six years.

Patient Name (Please Print)

Date

Patient, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S FILE AND MAINTAINED FOR SIX YEARS.

Dr Dale Cooper

CHIROPRACTIC PHYSICIAN

PERMISSION AND AUTHORIZATION FORM
REGARDING THE USE OF
ACUPOINT INTEGRATIVE TECHNIQUE (AIT)

PLEASE READ BEFORE SIGNING

I authorize the AIT Practitioner at Cooper Chiropractic Clinic, Inc to perform an AIT health analysis and to develop a program for me designed to improve my health and NOT for treatments or "cure" of any disease.

I understand that AIT is a safe, noninvasive method of analyzing the body's physical and nutritional needs. Imbalances or deficiencies in these areas could cause or contribute to various health problems.

I understand that AIT is not a method for "diagnosing" or "treating" any disease including cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of AIT testing or any natural health, nutritional or dietary programs recommended. I understand that AIT is a means by which the body's natural energy can be used as an aid to determine possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

NAME (print, please) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

SIGNED _____

(If a minor child, signature of parent or guardian)

WITNESS _____ DATE _____

101 N. Garden Street, Suite 100, Clearwater, FL 33755 USA

Tel: (727) 446-1141 Fax: (727) 466-9721



CONSENT FORM

LiteCure Deep Tissue Laser Therapy Treatment

Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this treatment, such as, pregnancy, Cancerous lesions, Melanomas/Sarcoids, Photosensitive Medications, Corticosteriods or cardiac conditions..

I understand there are no guarantees to this treatment.

I understand that to achieve maximum results, I will need several ongoing treatments.

I have read the enclosed consultation and understand the contents.

I agree to all of the above to have this treatment performed on me.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Dr. Dale Cooper

CHIROPRACTIC PHYSICIAN

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

(signature)

(date)

628 CLEVELAND STREET • SUITE #301 • CLEARWATER, FL • (727) 446-1141

PERSONAL HISTORY

Name _____ Address _____

City _____ State / ZIP _____

Home Phone _____ E-Mail _____

Social Security _____ Driver's License# _____

Circle one: Married Single Widowed Divorced Separated

Birthdate: _____ Cell Phone _____

Employer _____ Type of Work _____

Work phone _____ Spouse's name _____

Names and ages of children _____

Referred to this office by _____

Who's responsible for your bill? You, and: Spouse Workers' Comp Auto ins. Medicare Medicaid

Personal Health Insurance (Name) _____ Health card # _____

CURRENT HEALTH CONDITION

Purpose of this Appointment _____

Other doctors seen for this condition? Yes No Who? _____

Type of treatment _____ Results _____

When did this condition begin? _____ Has this condition occurred before? Yes No

Is this condition: Job-related? Auto accident Home injury Fall Other: _____

Drugs you now take: Nerve pills Pain killers/Muscle relaxers Blood pressure medicine

Insulin Other _____

Do you suffer from any other conditions than the one for which you are consulting us? _____

PAST HEALTH HISTORY

Major surgery/operations: _____

Major accidents or falls: _____

Hospitalizations (for other than the above) _____

Previous chiropractic care: None Doctor's name and approximate date of last visit _____

Patient Signature

The list below features diseases which may be seen unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

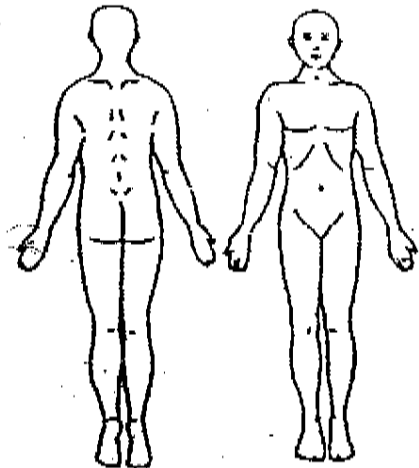
CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Pneumonia
- Polio
- Tuberculosis
- Anemia
- Measles
- Mumps
- Diabetes
- Cancer
- Heart Disease
- Thyroid Problems
- Arthritis

- Epilepsy
- Mental Disorders
- Eczema

DO YOU CONSUME:

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar



Please outline on the diagram the area of your discomfort.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST SIX MONTHS:

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Convulsions
- Cold/Tingling Extremities
- Stress

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems

- Vision Problems
- Dental problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MEN ONLY:

- Prostate/Sexual Dysfunction
- Other problems _____

WOMEN ONLY:

- Menstrual Irregularity
 - Menstrual Cramps
 - Vaginal Pain/Infection
 - Breast Pain/Lumps
- Other problems _____

When was your last period? _____

Are you pregnant?

- Yes No Not Sure

FAMILY HISTORY

The following family members have a same or similar problem as I have:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

CHIROPRACTIC ANALYSIS:

DO NOT WRITE BELOW THIS LINE.

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature