Lamb Chiropractic PC
Adam Lamb DC
315 Madison Ave @ 42nd St #511
New York, NY 10017

Health History

Name______________________________ **Date** ________________________

Address______________________________ **City/State/Zip**________________

Home Phone________________________ **Mobile** _____________________

Work Phone________________________ **Email**_______________________

Birthdate_____________

Referred By____

Past Chiropractic Care? YES NO DR'sName/Location____________________

Last Visit______

Current Medical Care? YES NO Why?

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Current Drugs/Medication____
Reason for Consulting This Office____________________________________

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Please Check The Choice Which Most Closely Describes Your Current Goals For Your Health And Wellbeing.

- o **I am only concerned about relief of a particular symptom.**
- o **I am only concerned about relief of a particular symptom, and preventing its return.**
- o **I want optimum health and wellbeing on every level available to me.**

<u>We Accept Payment by Cash, Check and Credit Card</u>

I understand that all services are to be paid in full at the time of services, unless other arrangements have been made and agreed upon writing.

Signature__________________________________**Date**______________________________

TERMS OF ACCEPTANCE

THESE ARE THE TERMS UNDER WHICH ALL PATIENTS ARE ACCEPTED FOR CARE IN THIS OFFICE:

IT IS CLEARLY UNDERSTOOD THAT THERE IS NO PROMISE OR OFFER OF ANY KIND, ON THE PART OF THE DOCTOR(S) OR THIS OFFICE, TO TREAT ANY SYMPTOM, CONDITION OR DISEASE.

ALTHOUGH I MAY HAVE COME TO THIS OFFICE WITH THE INITIAL EXPECTATION OF RELIEF OF A PARTICULAR SYMPTOM OR CONDITION, IT HAS BEEN CLEARLY EXPLAINED TO ME THAT THE ONLY PURPOSE OF CHIROPRACTIC CARE IS TO REMOVE OR REDUCE NERVE INTERFERENCE CAUSED BY THE PRESENCE OF A VERTEBRAL SUBLUXATION.

THIS CORRECTION IS UNDERTAKEN FOR NO OTHER REASON THAN THAT THESE VERTEBRAL SUBLUXATIONS INTERFERE WITH THE CAPACITY OF THE BODY TO FULLY EXPRESS LIFE.

SIGNATURE: ____ **DATE:** ______________

WITNESS: ____ **DATE:** ______________