UNIVERSITY of WESTERN STATES
Integrating Health and Science
2900 NE 132nd Avenue • Portland, OR 97230 • www.uws.edu
Phone: 503-206-3203 • Fax: 503-251-2837
Ckawaoka@uws.edu

# NEW PATIENT REGISTRATION

Today's Date:________________

Name:___________________________________________________________ Date of Birth:___________________________
Last First MI

Address*____________________________________________________________________________________________________
(Complete Mailing) Street Apt# City State Zip

Primary Phone* (_____) _______-______________

Secondary Phone* (_____) _______-______________

Email Address: ___________________________________________________________________________________________

Emergency Contact:______________________________ Relationship:___________ Phone: (_____) ______-_________
(Primary)

Emergency Contact:______________________________ Relationship:___________ Phone: (_____) ______-_________
(Secondary)

*Please notify our staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I understand that this alternative is available to me:

______________________________________________________________ ______________________________
Signature Date

## Authorization To Treat A Minor

As a parent or legal guardian, I hereby authorize treatment for the following:

____________________________________________________________ Date of Birth:_______________________
(Patient's Full Name)

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

Signature_________________________________________________ Date_________________________
(Parent or Legal Guardian)

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# CONSENT FOR EXAMINATION AND TREATMENT

I understand that the University of Western States, is a regionally accredited non-profit institution, for teaching and research, and that I may be examined and treated by students under the supervision of a licensed practitioner.

I understand that the University of Western States is a multidisciplinary facility. I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive any or all of the following: chiropractic adjustments, other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and therapeutic massage.

I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments and or massage therapy the most common side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck, which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side effects, complications and effectiveness of spinal adjustments and other treatments is available upon request.

I acknowledge by signing this form I have read and understand the above information.
I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that I have the right to revoke this consent, in writing, at any time.

________________________________________ ____________________
Patient's name (please print) Date

________________________________________
Signature of patient (Parent or guardian if patient is a minor)