CAMANO ISLAND CHIROPRACTIC CENTER
KATHY J. BATEMAN D.C., C.C.S.P.

Patient Name_____ Date_____

PLEASE READ THE FOLLOWING STATEMENTS ACKNOWLEDGING THAT YOU UNDERSTAND THE PURPOSE OF THE EXAMINATION METHODS AND MANEUVERS USED TO DETERMINE NECESSITY OF CHIROPRACTIC CARE IN THIS OFFICE. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE DOCTOR PRIOR TO SIGNING.

In the process of determining the need for chiropractic services, certain examination procedures may be employed to assist the doctor in making recommendations regarding diagnosis and treatment during the examination standard orthopedic and neurologic tests will be performed. Although the examining doctor will make every effort to assure that no unnecessary discomfort is experienced, the purpose of some of the orthopedic tests is to discover whether certain movements or procedures cause pain or make your symptoms more noticeable. If you experience discomfort or pain which you feel is excessive during the examination, please inform the doctor immediately.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

_____ _____
Signature of Patient Date

_____
Signature of Guardian (if necessary)

_____
Witness to signature

CAMANO ISLAND CHIROPRACTIC 1283 S. ELGER BAY RD. CAMANO ISLAND, WA
360-387-4502