MountainValley
CHIROPRACTIC

2026

CHIROPRACTIC CARE CONSENT

Thank you for choosing Mountain Valley Chiropractic. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions. All information will be held in the strictest of confidence.

Name_________________________________ Age____ DOB__________ M F Marital Status______ Phone__________________
Address____ City/State________________________ Zip_____________
Email ____________________________ Occupation______________________ **Enrolled in Medicare/Medicare Advantage? Y N**
Emergency Contact Name_____________________________________ Relation__________________ Phone________________
Who referred you to us? ____ May we thank him/her? Y N

*I voluntarily consent to be treated with chiropractic care by Joseph Heinecke, DC, of Mountain Valley Chiropractic.
*Mountain Valley Chiropractic does not accept assignments for Medicare or insurance. This means that Mountain Valley Chiropractic does not see any Medicare-enrolled persons. If you become Medicare enrolled while under the course of care by Mountain Valley Chiropractic, you will be referred to an appropriate Medicare provider. If you have insurance that contributes to your care, Mountain Valley Chiropractic will provide you with the appropriate documentation in the form of a "superbill" to help you with direct reimbursement from your insurance company. Mountain Valley Chiropractic cannot guarantee that your insurance company will reimburse you for services provided and assumes no role in recovering a reimbursement from your insurance company.
*I understand that chiropractic care involves hands-on touching of my body and can include sensitive areas including hips, sacrum, coccyx (tail bone), pubic bone, collar bones and ribs, lymph nodes in the armpits as well as palpation of muscles of both the upper and lower body. Some contact may need to be performed skin-to-skin, but most will be performed over my clothing. If at any time throughout the course of care I feel uncomfortable or do not want contact made with a specific body part, I will let Dr. Heinecke know so that other arrangements for care may be made. **Please initial for consent** _______
*I understand that some diagnostic or examination procedures may be performed if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Exams will be performed at the onset of care, annually, or in the instance of an auto accident or serious injury.
*I understand that chiropractic care involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Hands or an instrument is used to reposition anatomical structures. Potential benefits include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and well-being.
*I understand that no guarantees are given to me concerning the results and effects, and that I am free to stop or refuse treatment at any time. I also understand that there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. The best scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not.
*I understand that Dr. Heinecke does not diagnose or treat any condition other than Vertebral Subluxation. However, while under the course of care, if he finds or suspects a different or more serious condition requiring treatment, he will inform you as well as recommend that you seek the services of a healthcare provider that specializes in that area of treatment.
*Your privacy is important to us. Mountain Valley Chiropractic follows the Health Insurance Portability and Accountability Act (HIPAA). You have the right to review our HIPAA guidelines upon request. At times you may wish to contact Mountain Valley Chiropractic via email, or vice versa, for communication which may contain protected health information. **Initial** _______
*I understand payment is due at the time of service and I agree to address any financial concerns with Mountain Valley Chiropractic prior to treatment. I understand that Mountain Valley Chiropractic accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. **Initial** _______

*The above-named patient is a minor. As his/her parent/guardian, I give Dr. Heinecke permission to treat him/her without me being present at said treatment.
Please sign for consent to treat your minor child ____ Date__________________

I have carefully read and I understand the above information. I am fully aware of what I am signing.

____ ______________________________

Signature (Patient / Parent / Guardian) **Date**

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Infant Health History

(Ages 0-1)

Name: ____ DOB: _____________ Date: ____________

Parent(s)/Guardian(s) Name(s):____________________ Enrolled in Medicare/Medicare Advantage? Yes No

Chief Complaint: ____

How and when did it start? ____

What makes it better? ________________________ What makes it worse? _________________________

Has your child been treated for this condition before? Yes No If yes, by whom? ______________

Is your child currently under a healthcare provider's care for any other problems? Yes No

Previous Chiropractic Care: Last visit? Reason? Duration of care? ________________________________

____

Current Medications/Antibiotics/Supplements: ____

____

Past Medications/Antibiotics: ____

____

Hospital/ER Visits/Surgeries? ____

____

Other Injuries/Accidents: ____

____

Prenatal History

Complications During Pregnancy: (circle, if any)

Toxemia Diabetes Morning Sickness Heartburn Back Pain Headaches Other

Mother's Health/Nutrition: (circle one) Poor Good Excellent

Stress During Pregnancy: (rate 1-10) ____ Falls/Injuries/Accidents During Pregnancy: ______________

Family History of: (circle, if any) Diabetes Heart/Cardio Problems Other__________________

Complications During Delivery: (circle)

None C-Section Vacuum/Forceps Induced Epidural Fetal Distress Meconium Oxygen ICU

Birth Injuries: (list) ____

Birth Weight: _______________ Birth Length: _______________ APGAR: _____,_____

Feeding History:

Breastfed: (circle one) N Y - How Long? ____________ Difficulties? N Y - ______________

Baby Prefer One Side: N Y - Which? ___________ Formula? N Y - ______________

Introduced Solids: N Y - What? _______________ When? ____________________________

Food Allergies/Intolerances: N Y - List ____

Developmental History:

At what age was your child able to: Hold Head Up___ Roll Over___ Sit Up___ Crawl___ Stand___ Walk___

Vaccines: (circle)

Y N Partial Complete

Reactions, if any: (fever, fussy, etc.)

Slight Mild Severe

Describe reactions: ____

Check any of the following that your infant has suffered from:

□ Asthma

□ Digestive Difficulties

□ Ear Infections

□ Feeding Difficulties

□ Head Banging

□ Heart Conditions

□ Inconsolable Crying/Colic

□ Recurrent Fevers

□ Seizures

□ Spitting Up/Vomiting

□ Weight Loss/Poor Weight Gain

Parent or Guardian: _______________________Signature: __________________________ Date: ___/___/___