Draeger Chiropractic Clinic, S.C.
5105 Hwy 70 W/PO Box 2708
Eagle River, WI 54521
Ph: 715-479-5995 Fax: 715-479-1617
info@draegerchiropractic.com

AtlasPROfilax®

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail: _____ **Date of Birth:** _____

Injuries, accidents, hospitalizations and/or surgeries: _____

_____

Medications:_____

_____

Additional History:

Surgical Spinal Fusion	☐ no	☐ yes	Please specify_____
Congenital Spinal Fusion	☐ no	☐ yes	Please specify_____
Spinal injuries	☐ no	☐ yes	Please specify_____
Blood Pressure	☐ low	☐ normal	☐ high
Migraine Headaches	☐ no	☐ yes	Since when and how often_____
Tension Headaches	☐ no	☐ yes	Since when and how often_____
Dizziness	☐ no	☐ yes	Since when and how often_____
Pregnant	☐ no	☐ yes	
Depression	☐ no	☐ yes	
Insomnia	☐ no	☐ yes	
Stroke	☐ no	☐ yes	Please specify_____
Cancer	☐ no	☐ yes	Please specify_____
Diabetes	☐ no	☐ yes	
History of Fainting	☐ no	☐ yes	Since when and how often_____
Car Accident(s)	☐ no	☐ yes	Please specify_____
Blood Clots	☐ no	☐ yes	Please specify_____
Heart Attack	☐ no	☐ yes	Please specify_____
Seizures	☐ no	☐ yes	Please specify_____
ADD/ADHD	☐ no	☐ yes	Please specify_____
TMJ/Jaw Problems	☐ no	☐ yes	Please specify_____

ANY other health conditions:_____

_____

Are you currently being treated by a chiropractor?		☐ no	☐ yes	
Have you received an AtlasPROfilax® treatment before?		☐ no	☐ yes	
How did you find out about this treatment?	☐ internet	☐ doctor	☐ friend	☐ other

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The AtlasPROfilax® application does not replace medical treatment. I, the undersigned, understand that the AtlasPROfilax® application in not an alternative to a medical treatment or diagnosis. **DO NOT** interrupt or stop any ongoing medical treatments and any necessary treatments must not be postponed respectively. It is not intended to diagnose or prescribe medical or psychological conditions nor to claim to prevent, treat, mitigate or cure such conditions. No diseases, no symptoms of disease, no disorders and no sickness are treated.

I understand that the AtlasPROfilax® application given here is for the purpose of relief from muscular tension or spasm, increasing circulation and preventative maintenance for my body. The AtlasPROfilax® massagers are for experimental purpose only and are not FDA-approved. This method is not a chiropractic or osteopathic manipulation. No promises of cure have been made and I acknowledge that I am responsible for any consequences or reactions. Please see a qualified practicing MD for any disease or medical condition.

I understand that the practitioner must be aware of existing physical and/or mental conditions. Therefore, I have stated all my known medical conditions. I hereby waive all rights to any cause of actions against the practitioner, Dr. David D. Draeger, or his beneficiaries.

Regarding expected results, a study in Columbia found that 80% of clients report significant improvements from the very first session, while 15% of clients experience a healing crisis and 5% of clients do not report significant improvements.

The cost of the initial application is $350. The full amount is to be paid on the day of application without exceptions. This cost includes two (2) AtlasPROfilax® applications and one (1) full adjustment. **Any additional applications will cost $125 plus the cost of an adjustment** and will be due the day of application. I am aware that the costs associated with the application may not be covered by my insurance and that Draeger Chiropractic Clinic S.C. will not submit charges for the application to any insurance agency.

I understand that Dr. David D. Draeger may recommend accompanying the application with laser treatments. The cost of the AtlasPROfilax® and one (1) laser treatment will be **$500**. He may recommend the purchase of the AtlasPROfilax® and a package of three (3) laser treatments, the cost will be **$1000**. I am aware that if I choose to purchase these additional treatments, the full amount is to be paid the day of application.

I hereby acknowledge that I am signing this waiver of my own free will and that I understand it in full. This waiver will be governed by the laws of The State of Wisconsin.

Print Name: _____

Signature: _____ **Date:** _____

Guardian Signature: _____ **Relationship:** _____

To be completed by Draeger Chiropractic Staff only

Date of first application: _____ Payment Method: _____ Purchase Amount: _____

Staff Signature: _____ Date: _____