

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



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 | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Congenital Spinal Fusion | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Spinal injuries | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Blood Pressure | <input type="checkbox"/> low | <input type="checkbox"/> normal | <input type="checkbox"/> high |
| Migraine Headaches | <input type="checkbox"/> no | <input type="checkbox"/> yes | Since when and how often _____ |
| Tension Headaches | <input type="checkbox"/> no | <input type="checkbox"/> yes | Since when and how often _____ |
| Dizziness | <input type="checkbox"/> no | <input type="checkbox"/> yes | Since when and how often _____ |
| Pregnant | <input type="checkbox"/> no | <input type="checkbox"/> yes | |
| Depression | <input type="checkbox"/> no | <input type="checkbox"/> yes | |
| Insomnia | <input type="checkbox"/> no | <input type="checkbox"/> yes | |
| Stroke | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Cancer | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Diabetes | <input type="checkbox"/> no | <input type="checkbox"/> yes | |
| History of Fainting | <input type="checkbox"/> no | <input type="checkbox"/> yes | Since when and how often _____ |
| Car Accident(s) | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Blood Clots | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Heart Attack | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Seizures | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| ADD/ADHD | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| TMJ/Jaw Problems | <input type="checkbox"/> no | <input type="checkbox"/> yes | Please specify _____ |
| Fibromyalgia | <input type="checkbox"/> no | <input type="checkbox"/> yes | |

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

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

The AtlasPROfilax® application does not replace medical treatment. I, the undersigned, understand that the AtlasPROfilax® application is 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(s) 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(s), 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 \$480. 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 \$240 plus the cost of an adjustment** and will be due on 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 the doctor may recommend accompanying the application with laser treatments. The cost of the AtlasPROfilax® and one (1) laser treatment will be **\$680**. He may recommend the purchase of the AtlasPROfilax® and a package of three (3) laser treatments, the cost will be **\$1200**. 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: _____