Upper Cervical Chiropractic in Tulsa
7806 East 106th Street Suite 101
Tulsa, OK 74133

Care Waiver: _________________________ Date: _________

Doctor Recommended Duration and Frequency

When we make your recommendations for care, we take your case history, exam findings, age, the duration and severity of your problem, and your x-ray results into consideration. Every patient will respond differently, but fortunately, we have computerized thermographic instrumentation to help us determine whether or not you are healing. Your body will dictate how often you need to be checked but our short-term goal is for you to hold your correc-

Duration: ______ Visits: _____

Goals of care: Reduce the frequency and severity of symptoms, improve your range of motion and prevent premature arthritis. Improve your ability to hold your correction, see continued improvement in chief complaints and in overall health. Strengthen the muscles in your neck and back, increase stability in your spine, and achieve maximum improvement in your chief complaint and overall health.

Patient Revised Care

I ____understand the recommendations have been revised at my request and are against the doctors recommendations for care. I understand the revised care plan is not ideal for achieving optimal health and I accept care under these conditions.

Revised Duration: _________ Revised Visits:_______

Signature:_______________________________________ Date:______________________