

Chiropractic Works! Health and Wellness Center

Where Better Health Happens

Thank you for choosing us to help you with your health and wellness needs. This packet is designed to save you time in our office waiting room, filling out papers on a clipboard.

Please make yourself a cup of tea or something nice, sit down and take twenty minutes to thoroughly enter your current health status and let us know your health goals. There are a few items that are repeated for the sake of completing the health survey.

Because you will bring in a completed form, we will get to you more quickly and the doctor will be better prepared with a more complete health history.

Thank you again for being thorough. Enjoy the journey.

PERSONAL HISTORY

DATE: _____ Email Address: _____

NAME: _____ BIRTHDATE: _____

AGE: _____ GENDER: M F HEIGHT: _____ WEIGHT: _____

ADDRESS: _____

PHONE (____) _____ TYPE OF WORK: _____

CHECK ONE: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

NUMBER OF CHILDREN: _____ AGES: _____

WHO IS RESPONSIBLE FOR YOUR BILL? YOU AND: SPOUSE AUTO INSURANCE

PERSONAL HEALTH INSURANCE OTHER: _____ SSN: _____

Insured's Name: _____ Birthdate: _____ ID: _____

Insured's Employer: _____ Employer Phone: _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____

MAJOR COMPLAINT: _____

WHEN DID THIS CONDITION BEGIN: _____

WHERE WERE YOU WHEN THIS HAPPENED: _____

IF DISABLED FROM WORK, GIVE DATES: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

MEDICATION YOU NOW TAKE: NERVE PILLS PAIN KILLERS MUSCLE RELAXERS

BLOOD PRESSURE INSULIN ASPIRIN TYLENOL ALLERGY OTHER _____

PAST HEALTH HISTORY PLEASE CIRCLE OR DESCRIBE:

MAJOR SURGERY/OPERATIONS: APPENDIX TONSILS GALL BLADDER HERNIA

HEART BACK NECK LEG OTHER _____

MAJOR ACCIDENTS/FALLS: _____

OTHER HOSPITALIZATION: _____

PREVIOUS CHIROPRACTIC: LAST VISIT DATE _____ DR'S NAME _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION THIS LAST YEAR? YES NO

IF YES, PLEASE EXPLAIN _____

WHY CHIROPRACTIC? People go to Chiropractors for a variety of reasons. Some go for relief of painful symptoms (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (COMPREHENSIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so we may be guided by your wishes whenever possible.

- Relief Care Corrective Care Comprehensive Care
 Please have the doctor select the best type of care for my condition.

Date

Patient's Signature

If this is an accident-related injury, please ask for the Accident form.

**THE PURPOSE OF OUR CHIROPRACTIC HEALTH
AND NUTRITION CENTER IS TO SUPPORT
EACH INDIVIDUAL IN ACHIEVING THEIR
OPTIMUM LEVEL OF HEALTH AND TO EDUCATE
EACH PERSON SO THAT THEY MAY
UNDERSTAND HEALTH AND CHIROPRACTIC,
THEN IN TURN, EDUCATE OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as she deems appropriate through the use of manipulation throughout my body. It is understood and agreed the amount paid the doctor for x-rays is for examination, and the x-ray negative will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Date _____

Guardian/Spouse Signature Authorizing Care _____

PATIENT-DOCTOR AGREEMENTS

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

SIGN IN

When you arrive, sign in at the front desk and pull your treatment card out of the box. You will be called and assigned a treatment room in the order you signed in for your Doctor (given you have arrived on time for your appointment). When you go to the assigned treatment room, place the folder in the door tray and lie face down. Rest and relax, the Doctor will be in as soon as possible.

WELLNESS ORIENTATION WORKSHOP Stress and Wellness Seminars

It is mandatory that all patients attend our Wellness Orientation Workshop. This group consultation explains how the body functions, how Chiropractic works and how results are produced. Family and friends are welcome. There is no charge for the consultation. If you are unable to attend, extra time will be set aside on one of your visits and there will be an additional personal charge for a private workshop with the Doctor at a rate of \$4 per minute (normally we allow 30 minutes to cover all of the points). Please attend the next group workshop.

MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, be sure to make up the missed appointment within 7 days. If you miss your appointment or give less than a 24-hour notice and do not reschedule, there is a personal service fee of \$65.00.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check ups may take place. The fee for these services should be paid according to your payment agreement. Please refer to the Initial Visit Financial Policy you received

DIETS AND FOOD SUPPLEMENTS

Diets should be followed and vitamin supplements taken as recommended by your Doctor or the Nutrition Counselor. Any problem you may have with these recommendations should be communicated. We do not prescribe, but will make recommendations to help speed your recovery. You are expected to pay for food supplements at the time of purchase. If you experience problems with any supplements, handle it with the doctor.

NEW SYMPTOMS - IMPORTANT!

Notify us right away if you are experiencing pain or discomfort in areas not addressed in your initial consultation or if you have a new injury. **NOTE:** If you are scheduled during our busiest patient hours, the Doctor may not have the time to properly address your new complaint. If this is the case you will be rescheduled later that day or the next day so the proper work up can be done.

UPSETS

We are here to serve you. Please speak with your Doctor about any upsetting matter, i.e., long waits, staff insensitivity, confusion about treatment, etc. We see your comments as helping us to help you and others.

TERMINATION OF CARE

Do not dismiss yourself from care. We are ethically and legally responsible for your health care once we accept you as a patient. If you wish to discontinue care, notify the office and you will be scheduled for a no charge update consultation and examination to update your records.

If you stop care without this update consultation and exam you will be required to pay all outstanding fees in full immediately, regardless of previous financial arrangements. However, if you comply with this agreement we will honor whatever financial agreements are in place.

Patient's Signature

date

WOMEN'S HEALTH SCREEN

Name _____ Age _____ Today's Date _____

Current health problems/concerns: _____

Current medications, prescription (i.e. hormones) or over-the-counter _____

General Health (check any that apply):

Chronic fatigue ___ Irritability ___ Shortness of breath ___ Headaches ___ Bone pain ___ Memory fails ___

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months ___

Gynecological History:

Date of last gynecological exam (PAP, mammogram) Results, _____

Date of last menstrual cycle Length of cycle _____ Interval of time between cycles _____

Any recent changes in normal menstrual flow Age of first period _____

Form of birth control Number of children _____ Number of pregnancies _____

C-section ___ Surgical menopause, date _____ Describe Surgery _____

Endometriosis ___ Infertility ___ Fibrocystic Breasts ___ Fibroids/Ovarian Cysts ___ Reproductive cancer ___

Pelvic Inflammatory Disease ___ Vaginal Infections ___ Vaginal Yeast ___ Genital Herpes ___ STD ___

Family Medical History (check any that apply):

Breast or other cancers ___ Cardiovascular disease ___ Osteoporosis ___ Obesity ___ Alcoholism ___

Mental Illness/Depression ___ Alzheimer's ___ Diabetes ___ Arthritis _____ Stroke _____

Lifestyle & Diet:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____

Identify the major causes _____

Do you eat (check any that apply):

Sweets, sodas, ice cream ___ Fried foods ___ Whole grains, legumes, cereals ___ Fruits/vegetables _____

List your 4 favorite foods _____

Do you (check any that apply):

Diet frequently ___ Skip meals ___ How many meals do you eat per day ___ Dine out regularly ___

Use tobacco/smoke cigarettes ___ How many cigarettes per day _____ Exposed to passive smoke ___

Drink coffee ___ # cups per day ___ Strong ___ Mild ___ Decaffeinated ___ Eat Chocolate ___

Drink alcoholic beverages ___ How many ounces per day/per week Preference _____

Exercise daily ___ How many times per week/activity: _____

Do you restrict your intake of or avoid completely (check any that apply):

Dietary fat ___ Dairy products ___ Animal protein ___ Salt ___ Fiber ___ All animal foods ___

Check the symptoms you experience regularly one to two weeks before your period:

Part 1

1. ___ Anxiety
2. ___ Irritability
3. ___ Nervous tension
4. ___ Aggressive or hostile toward family/friends
5. ___ Engage in self destructive behavior
6. ___ Weight gain
7. ___ Water retention
8. ___ Abdominal bloating
9. ___ Tender, swollen and/or painful breasts
10. ___ Breast lumps increase in size and tenderness
11. ___ Discharge from nipples

12. ___ Craving for sweets
13. ___ Increased appetite
14. ___ Heart palpitations
15. ___ Fatigue
16. ___ Headaches
17. ___ Shaky or clumsy
18. ___ Depressed
19. ___ Withdrawn
20. ___ Confused
21. ___ Forgetful
22. ___ Insomnia/difficulty sleeping

Check the symptoms and/or behaviors that occur during your period with a frequency or intensity that affects your daily activities:

Part 2

1. Cramping in lower abdomen or pelvic area
2. Sharp intermittent pain
3. Dull aching pain
4. Upset stomach
5. Diarrhea
6. Nausea or vomiting
7. Low back aches
8. Headaches
9. Difficulty concentrating
10. Accident prone
11. Unusual fatigue (take naps)
12. Decreased productivity
13. Weight gain
14. Painful and/or swollen breasts
15. Irritability
16. Mood swings
17. Depression
18. Painful intercourse

Check off any of the following statements that describe your menstrual cycle, energy level or reproductive function:

Part 3

1. Heavy prolonged menstrual bleeding/clotting
2. Menstrual bleeding that lasts longer than 5 days
3. Absence of periods for 3 months or more
4. Vaginal itching, burning, dryness
5. Menstruation that occurs too frequently (every 21-24 days)
6. Irregular periods (once every three to six months)
7. Frequently skip periods
8. Menstrual cycle every 36 days or longer
9. Unusually light or heavy periods
10. Unusually light menstrual flow - "spotting"
11. Menses last three days and are light
12. Bleeding or spotting between periods
13. Bleeding between periods is light - "staining"
14. Bleeding between periods is heavy and/or clots
15. Abnormal vaginal discharge
16. Frequent urination

Check any of the following symptoms if they occur throughout the month with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself

Part 4

1. Decline of vital energy and sense of well-being
2. Hot flashes
3. Night sweats
4. Spontaneous sweating
5. Chills
6. Depressed
7. Irritable
8. Anxiety
9. Anger
10. Mood swings
11. Headaches
12. Forgetful
13. Difficulty concentrating
14. Difficulty sleeping
15. Urinary problems
16. Vaginal problems
17. Dry skin
18. Bleeding between periods
19. Irregular periods
20. Stopped menstruating
21. Joint and muscle pain
22. Change in sexual desire
23. Difficulty with orgasm
24. Painful intercourse
25. Loss of muscle tone
26. Vaginal bleeding any time
27. Vaginal bleeding after sex
28. Vaginal discharge

Chiropractic Works! *Applied Kinesiology Science Based Nutrition Health Coach®*

Past Medical, Holistic, Nutritional Testing Procedures and Results:

Date	Test/Procedure	Results

Amount of Water per day _____ cups/liters Caffeinated Beverages _____ ounces
Number of Bowel Movements per day/week (circle one) _____ light brown dark brown green
Stools: well formed (in logs) loose constipated/hard watery diarrhea hemorrhoids polyps
Stomach aches Sensitive Stomach Gas/Bloating between meals Gas/Bloating immediately after meals
Diet: Vegan Vegetarian Mixed(animal and plant) Diabetic Diet other _____
Artificial Sweeteners use: aspartame sucralose saccharin corn syrup high fructose corn syrup
Number of Meals per week out at a restaurant/deli/fast food _____
Blood Type: O A B AB
Genetic Heritage: _____
Birth Defects: _____
Dental Health: dentures partials crowns bridges amalgam/metal fillings root canals “red toothbrush” puffy gums black gums bleeding gums mouth sores cold sores white tongue
Vision: surgically corrected _____ wear glasses/contacts vision deteriorating
Sinuses/Throat: Sinusitis Stuffy Nose Runny Nose Sneezing Mucus Surgery
Hearing: ringing/tinnitus loss of hearing plugged ears ear wax itchy ear canals
Immune System: Auto Immune Disease _____ Frequency of Cold/Flu _____
Allergies: _____
Concentration: difficulty diminishing can’t multi-task memory get easily lost while driving
Skeletal: getting shorter arthritis bone pain osteoporosis other _____
Muscular: spasms weakness Charlie horse tires easily with little effort can’t exercise
Cardiovascular: heart condition _____ rapid or slow heart rate pounding in chest while resting
chest/shoulder/arm pain related to heart blue fingernails/lips/nose/ears hardening of arteries
Reproductive and Bladder: ovary/testes trouble uterus/prostate trouble fertility trouble
Feet/Ankles: dropped arches high arches deformed toes, foot or ankle orthotics
Joints or other body parts replaced or transplanted _____

Medications:

Date Prescribed	Medication	Diagnosis

Nutritional Vitamin Supplements/Herbs/Homeopathic Remedies:

Supplement Name	Duration of Use	Reason

Anything else you would like the doctor to know?

Health and Wellness Center Where Better Health Happens

Pain Chart (full body)

Pain Representation

Ache
 V V V V V V V
 V V V V V V

Burning
 = = = = =
 = = = = =

Numbness
 O O O O O O O O
 O O O O O O

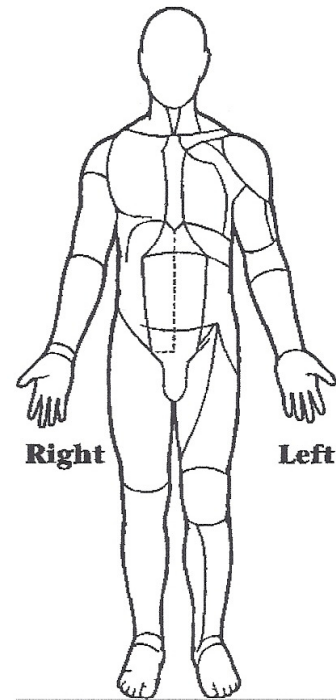
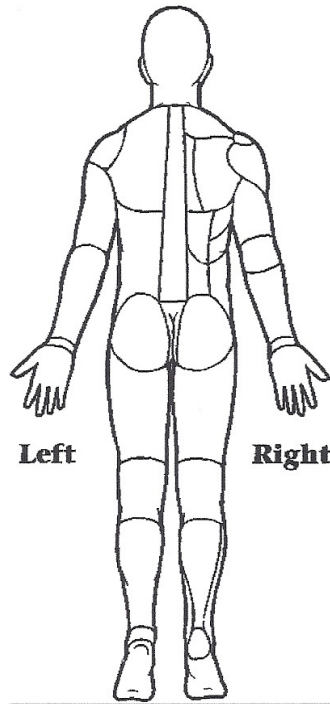
Pins & Needles
 ● ● ● ● ● ● ● ●
 ● ● ● ● ● ● ● ●

Stabbing
 / / / / / / / /
 / / / / / / / /

Other
 X X X X X X X
 X X X X X X

 Patient's Name

Draw location and type of pain on the body outline and mark the degree on the pain line at the bottom of the page.



Back

Front

No Pain **Worst Pain Possible**
Please make a slash through this line to indicate the level of your pain.

 Patient's Signature

 Date

**INFORMED CONSENT TO CHIROPRACTIC
ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient or by patient's representative if necessary, e.g., if patient is a minor or physically or legally incapacitated:

Print Patient's Name

Signature of Doctor

Date

Signature of Patient or Patient's Representative

Date

Print Patient's Representative's Name

Representative's Relation to Patient

Financial Agreement

Cash Payment

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, I would first like to explain how your medical bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for consultation, examination, treatment, supports and nutritional supplements are due at the time the service is provided.

If this arrangement is becomes a problem for you, please see our office manager so that other arrangements can be made for you.

If you need any reports or forms completed by the doctor, a customary fee for such reports or forms will be charged in addition to the normal fees for services. You will be notified of any additional charge prior to the doctor writing any reports or forms.

Our policy requires you give us 48 hours notice to cancel an appointment so that we have time to give this appointment to someone else. We have a \$65 missed appointment fee.

It is also the policy of this office that if you should suspend or terminate your care or treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

Once again, we'd like to welcome you to our office. If you have any questions at any time, please don't hesitate to ask.

I have read and understood the above agreement between the office and myself.

Patient's signature

date

Patient's name printed

Parent/Guardian's name printed

Parent/Guardian's signature