

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

Our chiropractic method of correction of subluxation(s) is by specific adjustments of the joints of the body. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. If, during the course of examination or treatment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I, the undersigned, hereby authorize the doctors in this chiropractic office and whomever she may designate as her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Date: _____

Patient's/guardian signature _____

Witness _____

OWNERSHIP OF X-RAY FLIMS

It is understood and agreed that the payments to the Doctor for X-rays is for examination of x-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____

PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____
Zip _____ Home phone _____
Birth date _____ Cell Phone _____
Age _____ Gender _____ Number of children _____
Employer _____
Work address _____
Work phone _____
Type of work _____
Marital Status _____
Social Security # _____
E-mail address _____
Payment method Cash Check Credit card

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to

- Job Sports Auto Fall
 Home Injury Chronic Discomfort Other

Please explain _____

If job related, have you made a report of you accident to your employer? Yes No

When did this condition begin? _____

Has this condition

- gotten worse stayed constant comes and goes

Does this condition interfere with

- Work Sleep Daily routine Other activities

Please explain _____

Has this condition occurred before? Yes No

Please explain _____

Have you seen other doctors for this condition? Yes No

Doctor's Name(s) _____

Type of treatment _____

Results _____

ABOUT THE PARTNER

Name _____
Employer _____
Work phone _____
Type of work _____

HEALTH HABITS

	No	Yes
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink coffee, tea or soda?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear:		
<input type="checkbox"/> Heel lifts <input type="checkbox"/> Sole lifts <input type="checkbox"/> Inner soles <input type="checkbox"/> Arch supports		

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you seen or heard about us in/on: ___ Paper ___ Clinic Sign ___ YP

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? Yes No

Has any child in your family seen a Chiropractor? Yes No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Doctors of Chiropractic work with the nervous system? Yes No
- The nervous system controls all bodily functions and systems? Yes No
- Chiropractic is the largest natural healing profession in the world? Yes No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care** – Symptomatic relief of pain or discomfort
- Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.

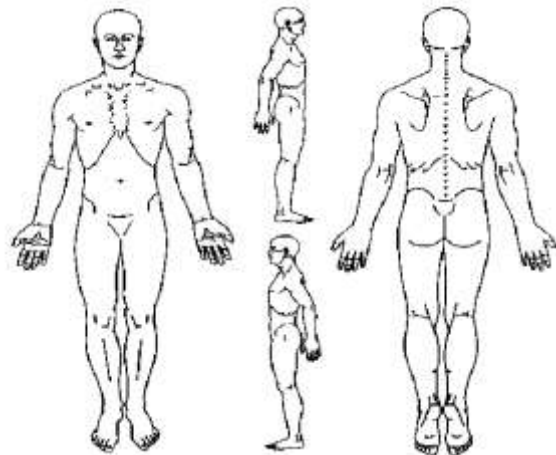
Patient's signature

Date

MEDICATIONS I NOW TAKE

- Cholestral medication
- Stimulants Blood thinners
- Tranquilizers Pain killers (including aspirin)
- Muscle relaxers _____
- Insulin _____

Vitamins & Supplements I now take: _____



N=NUMBNESS P=PAIN T=TINGLING ST=STIFFNESS

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/
Pacemaker | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Numbness in Arms/legs/hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Pain in Arms/legs/hands | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Thyroid problems |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Surgeries |
| | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> _____ |
| | | <input type="checkbox"/> _____ |

For women:

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control? Yes No
- Do you experience painful periods? Yes No
- Do you have irregular cycles? Yes No
- Do you have breast implants? Yes No

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