General Information

FIRST NAME_____ LAST NAME_____ Today's Date_____/____/____

Address_____ City_____

State_____ Zip Code_____ Birth Date _____/_____/_____

Home # ( ) _____ Cellular # ( ) _____

E-Mail Address_____ Occupation_____

_____Male _____ Female # of Kids_____

_____Single _____Married ____Divorced____ Widowed Name of Spouse_____

Names and ages of kids_____

Main reason for consulting our office? _____

Referred by_____

"Please check if you are here for any of the following": _____Car Accident _____Work Injury _____Other Injury

Your Health Profile

Why this form is important- As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a **lifetime** of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

The Beginning Years- Many of the health challenges that people face later in life have their origins in stresses from the development years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History- Please check those items that apply to you

_____Mother smoked/drank/drugs in pregnancy _____Epidural/Meds in labor _____Breech Vaginal Delivery
_____Forceps Delivery _____Vacuum Extractor Used _____Labor Induced
_____C-Section Delivery _____Premature/Overdue _____Complications
_____Very Short Labor _____Very Long Labor
_____Other_____

Childhood Years (Age 0-17 yrs) - Please check those items that apply to you

_____Recurrent Childhood Illness _____Serious Falls _____Active in Sports
_____Car Accident(s) _____Surgery/Stitches _____Alcohol/Drug Abuse
_____Smoker _____Antibiotics/Other Medications _____Vaccinated
_____Broken Bones _____Severe Emotional Stress _____Under Chiropractic Care
_____Other_____

Adult Years (Age 18 to present) - Please check those items that apply to you

_____Present Smoker	_____Former Smoker	_____OTC/Prescription Meds
_____Alcohol Use	_____Surgery/Stitches	_____Play Sports
_____Car Accident(s)	_____Work Injury	_____High Job Stress
_____High Personal Stress	_____Sit a Lot	_____Drive a lot
_____Poor Sleep	_____Not Enough Sleep	_____Poor/Inadequate Diet
_____No Exercise	_____Flat Feet	_____Wear Orthodics / Lifts
_____Severe Health Problems	_____Hard Falls	_____Broken Bones

_____Other Injuries_____

_____Have been under chiropractic care in the past - How long ago was your last adjustment? _____

Clarifying Your Health Objectives

In addition to the main reason for your first visit today, what additional health objectives do you have for your future?_____

_____

Have you ever been to another doctor who put you on a Health Development Program? [ ] Yes [ ] No [ ] Not Sure
If yes: Doctor's Name_____ [ ] Medical Doctor [ ] Chiropractor [ ] Other

How long were you able to stay on the program?

What were your results?

Were the results permanent? [ ] Yes [ ] No [ ] Somewhat

Are you as healthy (or healthier) today as you were 5 years ago? [ ] Yes [ ] No [ ] Don't Know
If yes, what strategies have you used?

Will you be as healthy (or healthier) as you are today, 5 years from now? [ ] Yes [ ] No [ ] Don't Know

If yes, what strategies will you implement to get there? _____

If no or don't know, what strategies could you implement to get there? _____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed_____ Date _____ / _____ / _____

Office Fee Schedule and Financial Policy

Service

Consultation	N/C
Initial Exam	$90-120
1 - 2 Region Adjustment	$60
3-4 Region Adjustment	$70
5 Region Adjustment	$80
Extremity Adjustment	$50

Wellness Plans

After your zones have been balanced, a customized wellness plan can be discussed with the doctor.

Financial Policy

We are committed to providing you the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time services is rendered unless other arrangements are made in advance. Other arrangements include our yearly Corrective Adjustment Plans (CAP), monthly Cap plans, weekly payment plans, or extended payment plans. Details of these plans will be discussed with you when the doctor goes over your recommendations to get your 6 Health Zones as healthy as possible.

_____***Health Insurance****:* If you have insurance that covers chiropractic care, we will utilize it to help pay for your chiropractic care. Our commitment is to your health, not your insurance coverage. ***Your treatment plan is based on your individual needs not your coverage. Remember, your agreement with the insurance company is between you and them, not us and them.***

_____

Patient Signature Date

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I _____ have read and fully understand the above statements. (Print Name)

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

(Signature) (Date)