

Personal History

Date: _____

Name: _____ Address: _____
City: _____ State /Prov: _____ Zip/Postal Code: _____
Home Phone: _____ Birth Date: _____ Age: _____
Cell Phone : _____ Sex: [] Male [] Female
Social Security # _____ Circle One: Married Single Divorced Widowed
E-mail Address: _____
Business Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____
Spouse's Employer _____
Type of Work _____ Names and Ages of Children: _____

How were you referred to our office? _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who is responsible for your bill, [] Self [] Worker's Comp. [] Auto Insurance [] Medicare

Current Health History

Purpose of this Appointment _____
Other Doctors seen for this condition: [] Yes [] No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? [] Yes [] No
Is Condition: [] Job Related [] Auto Accident [] Home Injury [] Fall [] Other _____
Date of Accident: _____ Time of Accident _____
Have You Made a Report of Your Accident to Your Employer? [] Yes [] No
Drugs You Take Now: [] Anti-Depressants [] Pain Killers/Muscle Relaxers [] Blood Pressure Medicine
[] Insulin [] Other _____
Do You Wear a Shoe Lift / Insert? [] Yes [] No
Do You Suffer From Any Other Condition *Other Than* That Which You Are Now Consulting Us? _____
Name of Your Primary Care Provider? _____ Office Phone # _____

Past Health History

Please Check and Describe:
Surgery / Operations: [] Appendectomy [] Tonsillectomy [] Gall Bladder [] Ear Tubes/Adenoids
[] Broken Bones [] Back / Neck Surgery [] Other _____
Accidents or Falls: _____
Hospitalizations (Other Than Above): _____
Previous Chiropractic Care: [] None [] Doctor's Name & Approximate Date of Last Visit _____

Lifestyle

Do you exercise? []Yes []No How often? (circle) 1X 2X 3X 4X 5X /per week Other: _____

What activities? []Running []Jogging []Weight Training []Cycling []Yoga []Pilates []Swimming
[]Other _____

Do you smoke? []Yes []No How much? _____

Do you drink alcohol? []Yes []No How much / week? _____

Do you drink coffee? []Yes []No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Health Conditions

Accumulation of Physical, Chemical and Emotional Stressors lead to Nerve Stress on your entire body. This nerve stress leads to a body that has challenges adapting, healing, functioning and feeling good. Slips, falls, accidents and abnormal postural habits lead to spinal misalignments which cause undetected nerve damage. Our food choices and prolonged uses of medications lead to toxicity and chronic emotional stress leads to hormone imbalances (adrenaline/cortisol). It has been extensively documented that accumulated nerve stress will weaken and distort the overall structure of your spine and will negatively impact overall organ function and health. The areas of nerve stress will determine the organs affected and its affect on your body's health.

1. Accumulated nerve stress in your neck (Cervical Spine) leads to the following. In the past or presently, have you experienced:

- | | |
|--|---|
| <input type="checkbox"/> Low Energy / Fatigue | <input type="checkbox"/> Coldness in Hands |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into Shoulders/Arms/Hands | <input type="checkbox"/> Recurrent Colds/Flu |
| <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Hearing Disturbances |
| <input type="checkbox"/> Weakness in Grip | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> TMJ Pain / Clicking | <input type="checkbox"/> Allergies/Hay Fever |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Ear Infections |

2. Accumulated nerve stress at your mid/upper back (Thoracic Spine) leads to the following. In the past or presently, have you experienced:

- | | |
|---|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Pain Into Your Ribs/Chest |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Tired / Irritable after eating |

3. Accumulated nerve stress at your lower back (Lumbar Spine) leads to the following. In the past or presently, have you experienced:

- | | |
|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Low back pain |

Do Not Write Below This Line

Chiropractic/Acupuncture/Nutritional Analysis

Patient Accepted : [] Yes [] No [] Referred

Doctor's Signature

Consent to Care

I do hereby authorize the doctors of The Chiropractic Wellness Connection to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow 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, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

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 related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and 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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, 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 conditions(s) for which I seek treatment.

Signature _____ Date _____
(If under age 18) Parent's signature

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature _____ Date _____
(If under age 18) Parent's signature