True Chiropractic Wellness Registration Form

CONFIDENTIAL PATIENT INFORMATION:

Name: _____ S.S.#: _____ -_____-_____ Today's Date: _____ /_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ /_____ /_____ Sex: ❐ Female ❐ Male Weight: _____ Height: _____

Status: ❐ Minor ❐ Married ❐ Single ❐ Other Referred by: _____

Your Employer: _____ Occupation: _____

Spouse/Parent's Name: _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

HEALTH HISTORY:

Do you currently have or have you previously had any of the following symptoms?

❐ Headaches	❐ Tension	❐ Loss of Taste
❐ Neck Pain	❐ Irritability	❐ Loss of Memory
❐ Neck Stiffness	❐ Mood Swings	❐ Loss of Smell
❐ Mid Back Pain	❐ Sleeping Problems	❐ Upset Stomach
❐ Low Back Pain	❐ Fatigue	❐ Urinary Problems
❐ Arm Pain	❐ Depression	❐ Constipation
❐ Leg Pain	❐ Chest Pain	❐ Diarrhea
❐ Pins and Needles in Arms	❐ Shortness of Breath	❐ Heartburn
❐ Pins and Needles in Legs	❐ Cold Sweats	❐ Ulcers
❐ Numbness in Fingers	❐ Fever	❐ Menstrual Pain/Irregularity
❐ Numbness in Toes	❐ Fainting	❐ Hot Flashes
❐ Cold Hands	❐ Dizziness	❐ Allergies
❐ Cold Feet	❐ Ringing/Buzzing in Ears	❐ Skin Issues
❐ Nervousness	❐ Light Sensitivity with Eyes	❐ Autoimmunity

Have **YOU** (○) or **A FAMILY MEMBER** (❐) ever been diagnosed with any of the following conditions?

○ ❐ AIDS/HIV	○ ❐ Heart Disease	○ ❐ None
○ ❐ Cancer	○ ❐ Diabetes	○ ❐ Unknown
○ ❐ High Blood Pressure	○ ❐ Stroke	○ ❐ Other

Purpose for contacting us: _____

Have other doctors been seen for this condition? N / Y , if Yes, Doctor's name and prior treatments (Including Medication):

_____

Date of onset: ____/____/_____ Onset was: ❐ Sudden ❐ Gradual ❐ Associated with an event

Duration of problem or episode: ❐ Minutes ❐ Hours ❐ Days ❐ Months ❐ Years

Pattern of problem: ❐ Constantly ❐ Intermittent ❐ Occasional ❐ Cyclical

Is the condition getting worse? ❐ No ❐Yes Does anything relieve your pain?_____

Initiating/aggravating factors: _____

Please describe any other activities that are restricted: _____

Have you ever been diagnosed with a Subluxation? ❐ No ❐ Yes, When?_____

Have you seen a Chiropractor for this or any other condition? ❐ No ❐ Yes, When? _____

Which best describes your health goals: ❐ Pain relief only ❐ Correct entire problem ❐ Optimal Health & Wellness

Women Only: Is there a possibility that you may be pregnant? ❐ No ❐ Yes, Date of last menstrual period: _____/_____/_____

PHYSICAL STRESSORS

Have you ever been involved in an auto accident? □ No □ Yes: If yes, how many? _____ Date of most recent accident: _____

Please describe the auto accident: _____

Have you ever suffered a concussion? □ No □ Yes: If yes, how many? _____ Have you ever been knocked unconscious? □ No □ Yes

Have you ever or do you currently participate in any contact sports (ex: football, soccer, gymnastics, martial arts, etc)? □ No □ Yes

Have you ever broken any bones? □ No □ Yes: If yes, please explain: _____

Have you ever suffered a sprain (ligament) or strain (muscle) injury? □ No □ Yes: If yes, please explain: _____

_____

Have you ever had any surgeries? □ No □ Yes: If yes, please explain: _____

Do you spend the majority of you day sitting? □ No □ Yes: How many hours per day? _____

How many hours per day do you spend on the computer, watching television, playing video games and reading? _____

How would you rate your posture? □ Excellent □ Good □ Fair □ Poor

How would you rate your balance and coordination? □ Excellent □ Good □ Fair □ Poor

How many hours of exercise do you get per day? _____ What do you do for exercise? _____

Do you have any physical limitations? □ No □ Yes: If yes, please explain: _____

CHEMICAL STRESSORS

Do you currently or have you ever used tobacco products? □ No □ Yes: If yes, how many per day? _____ How long? _____

Do you drink alcohol? □ No □ Yes: If yes, how many per week? _____ Do you use recreational drugs? □ No □ Yes: If yes, what? _____

Have you ever been prescribed antibiotics? □ No □ Yes: If yes, how many times? _____ When was your last dose? _____

Are you currently taking any medications? □ No □ Yes: If yes, please list them and explain what you are taking them for: _____

_____

Please list any medications used in the past (prescription or over-the-counter): _____

Were you vaccinated? □ No □ Yes Do you get the flu shot? □ No □ Yes: If yes, how many? _____

Do you consume processed foods or refined sugars? □ No □ Yes How many servings of grains / dairy do you consume daily? _____

How many times per month do you eat fast food? _____ Do you drink soda/diet soda? □ No □ Yes: If yes, how many per week? _____

Do you use any diet products (low/no fat or sugar)? □ No □ Yes Do you use artificial sweeteners (ex: aspartame, etc.)? □ No □ Yes

How many servings of fruits and vegetables do you consume daily? _____ What percentage of your food is organic? _____

Have you ever or do you currently have any amalgam dental fillings? □ No □ Yes Does your toothpaste contain fluoride? □ No □ Yes

Do you drink tap water? □ No □ Yes Do you drink water from plastic bottles? □ No □ Yes Do you use a shower filter? □ No □ Yes

Do you cook with Teflon or non-stick cookware? □ No □ Yes Do you use chemical based household cleaners? □ No □ Yes

EMOTIONAL STRESSORS

Have you recently (within last 2 yrs): Moved □ No □ Yes Changed jobs/schools? □ No □ Yes Suffered a severe illness? □ No □ Yes

Lost a family member or pet? □ No □ Yes Married? □ No □ Yes Divorced? □ No □ Yes Had a baby? □ No □ Yes

Do you currently have any stressful relationships (ex: spouse, child, parent, boss, co-worker, teacher? □ No □ Yes

Have you ever been abused physically, sexually or emotionally? □ No □ Yes Have you ever been bullied? □ No □ Yes

Do you feel overwhelmed at work or school? □ No □ Yes Do you have a hard time concentrating? □ No □ Yes

Are you easily agitated? □ No □ Yes Do you have a history of depression or anxiety? □ No □ Yes Do you feel unlucky? □ No □ Yes

Do you have difficulty sleeping? □ No □ Yes Do you have nightmares or recurring unpleasant dreams? □ No □ Yes

Do you have financial concerns? □ No □ Yes Do you feel anxiety about your health, physical or emotional wellbeing? □ No □ Yes

Do you regularly practice positive emotion habits (ex: prayer, meditation, positive affirmations, positive visualizations)? □ No □ Yes

How would you rate the amount of stress (physical, chemical, emotional) on your body? □ Excessive □ High □ Medium □ Low

Financial Agreement

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our clients are able to receive the needed care in an affordable manner. Financial reimbursement through insurance coverage is based on a contract between you and your insurance company. If you would like to use your insurance, we will be happy to supply you with a weekly statement that you can submit to your insurance. Reimbursement amounts will vary based on your specific insurance policy. Insurance companies do not provide reimbursement for wellness care. Payment is your responsibility and is due at the time of service. **The doctor will discuss all fees before any services are provided**.

I have read and understand the statements above.

Name:_____Signature:_____Date:_____/_____/_____

In the event there is a balance of outstanding charges on your account over 60 days, a credit card will be kept on file.

Name on card: _____Type of Card: _____

Card Number:_____Expiration Date:_____/_____/_____

INSURANCE

*** Please give our receptionist your insurance card and drivers license so we can make a copy for billing purposes.**

Company _____ID #_____ Group #_____

Secondary Insurance _____ID# _____ Group# _____

Release: I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the doctor to release all information requested for payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

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 parties to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: The 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.

Extremity subluxation: A misalignment of one or more of the extremity joints resulting in alteration of nerve function, joint function, and the surrounding supporting soft tissue structures (ligaments, muscles, fascia).

Adjustment: The 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 and extremities.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek services of another 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 methods are specific adjustments to correct vertebral subluxations, extremity subluxations, and offer nutritional and rehabilitative support for those subluxations.

Education on nutrition, exercise, stress management, wellness and overall wellbeing will be included throughout care.

ACCEPTANCE

I, _____ have read and fully understand the above statements.
Print Name
All questions regarding the doctor's 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**

Consent to evaluate and adjust a MINOR child

I, _____ being the parent or legal guardian of _____
Print Name **Print Child's Name**

I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____
Signature **Date**

Informed Consent

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

The nature of chiropractic treatment includes therapeutic ice and the chiropractic adjustment, where the doctor will use his/her hands to move specific joints. There will typically be an associated sound with the movement, similar to popping knuckles.

Like most health care procedures, there are possible risks associated with the chiropractic adjustment. However, unlike many such procedures, these documented risks are extremely rare. The following are the known risks.

It is not uncommon to experience temporary soreness as if going to the gym for the first time. A very small percentage of people may feel pain, tingling or numbness, cramps or tightness in their extremities.

When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

There is a one in ten million chance of a rare type of stroke associated with certain types of cervical (neck) manipulation. We do not employ that type of procedure at this office. In addition, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.

Other treatment options which could be considered may include the following:

Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases

Medical care. Including prescribed anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization. In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery. In conjunction with medical care adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

The risk of remaining untreated will allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles.

I have read the explanation above. I will have had the opportunity to have any questions answered to my satisfaction. I acknowledge that no guarantee can be given as to the results or outcome of my care. I have fully evaluated the risks and benefits of undergoing treatment, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**