

Center For Life Chiropractic, P.C.

A HEALTH & WELLNESS CENTER

Name _____ Date _____

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

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Best Number to contact you: Home Work Cell Email Address: _____

Birth Date: _____ Age: _____

Sex: M F Circle one: single married widowed divorced separated

Occupation: _____ Business Name _____ Spouse's occupation: _____

Spouse's Name: _____ Name and Ages of Children: _____

Whom may we thank for referring you to Center For Life Chiropractic? _____

Main reason for consulting our office today: _____

Anything about your Nerve System and Spine we should know about? _____

What is your level of commitment to yourself, your life and well-being? ___High ___Medium ___Low

Have you ever sought the services for this or any other health concern from the following:

- ___Massage therapist ___Acupuncturist ___Naturopath ___Yoga Studio
- ___Personal Trainer ___Nutritionist ___Rolfer ___Pilates
- ___Physical Therapist ___Chiropractor ___Other _____

Have you been adjusted by a chiropractor before? ___Yes ___No

Who: _____ Date of last Adjustment: _____

Frequency of visits: _____ times a week/month Duration of care: _____ weeks/months/yrs

- What is your daily fluid intake: Coffee ___/wk Alcohol ___/wk Water ___/day Soda ___/wk
- Sleep/Rest Habits: Daytime naps: Y N Hours a night: ___/hrs Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often)

- What type of work do you do? _____ Satisfied/Enjoy your work Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (if yes, please list)
- What are your current play and relaxation activities

Check any of the symptoms or conditions below that you experience:

- | | | | |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Problem Sleeping | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Pain Between Shoulder Blades |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Low-Back Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tension across top of shoulders |
| <input type="checkbox"/> Sciatic Pain | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Numbness in Arms/legs |
| <input type="checkbox"/> Leg or Hip pain | <input type="checkbox"/> Weight Trouble | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Other _____ | | | |

Which one of the above symptoms is worst? _____ How long have you had it? _____
 When it is at its worst, how does it feel? _____

The following 3 areas can contribute to nerve interference and diminished quality of life.

Circle the areas that apply to you and when.

	C=Child	T=Teenager	A=Adult	N=Not at all (please circle)	
<u>Physical Stress</u>				<u>Emotional Stress</u>	
Birth Stress	C T A N			Relationships	C T A N
Slip/Fall	C T A N			Career	C T A N
Car Accident	C T A N			Family	C T A N
Sports Injury	C T A N			Money	C T A N
Physical Abuse	C T A N			Fast paced Life	C T A N
Work Injury	C T A N			Hold in Feelings	C T A N
Poor Posture	C T A N			Quick Tempered	C T A N
Sitting on wallet	C T A N			Perfectionist	C T A N
Stomach sleeper	C T A N			Procrastinator	C T A N
Computer work	C T A N			Loss of loved one	C T A N
Repetitive lift/bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken Bones	C T A N				
Lack of Physical Activity	C T A N				
Excess Physical Activity	C T A N				
				<u>Chemical Stress</u>	
				Environmental	C T A N
				Smoker	C T A N
				2 nd Hand Smoke	C T A N
				Caffeine	C T A N
				Artificial Sweeteners	C T A N
				Prescription Drugs	C T A N
				Recreational Drugs	C T A N
				Self Medicate	C T A N
				Poor Diet	C T A N

TERMS OF SERVICE

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used 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 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 vertebrae 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 wisdom/ability to express the 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 condition 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 subluxations**. If a lifetime of a better functioning body is what you want for you, your family, and friends, then you are in the right place.

I, (Printed Name) _____ (Signature) _____ undertake chiropractic services on the understanding of and agreement with, the above explanation. _____ (Date).

Consent to evaluate and adjust a minor and/or child: I, _____ (Print Name) being the parent or legal guardian of _____ (Print Name) give permission for my child to receive chiropractic care.

General Physical Stress

Have you, (even as a passenger, even if you do not think you were hurt,) been involved in a vehicular collision or near collision? Please list approximate dates and severity (Mild, Moderate, or Extreme.)

Please list any other physical traumas including bicycle, ATV, boating, skiing/snowboarding, etc. List approximate dates and severity (Mild, Moderate, Extreme)

Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine? Yes No
Please list:

Have you ever had any broken bones? Yes No
Please explain:

Please list any other physical traumas that you feel have affected the health and quality of your spine and nervous system:

The following are authorizations regarding informed consent and permissions under the HIPPA act.

THE PERSON IDENTIFIED AUTHORIZES CENTER FOR LIFE CHIROPRACTIC, P.C. TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Center For Life Chiropractic, P.C. to use my name, address and phone number to contact me with appointment reminders, missed appointments, greeting cards, as well as information about chiropractic care.
2. If Center For Life Chiropractic, P.C. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
3. If you have insurance benefits and elect to use these benefits, we will use your information to process your insurance claims electronically, by fax or by mail. The following release gives permission to use your information to process your claim. I also authorize payment of medical benefits to Center For Life Chiropractic, P.C. for services rendered.
4. By signing this form you are giving Center For Life Chiropractic, P.C. permission to use and disclose your health information in accordance with the directives listed above.

EXPIRATION

The Authorization is effective as of January 1, 2009. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Center For Life Chiropractic, P.C. The written notice must contain the following information:

- Your name, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request: and your signature

You have the right to refuse to sign this AUTHORIZATION

If you refuse to sign this AUTHORIZATION, Center For Life Chiropractic, P.C. will still provide service to you.

Signature _____ Date _____

If a minor, or represented by another party

Signature of Personal Representative _____

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 DR. JASON A. FRIEDMAN, D.C.