CHANGING LIVES THROUGH THE CHIROPRACTIC EXPERIENCE

Center For Life Chiropractic, P.C.

A HEALTH & WELLNESS CENTER

Name: _____ **Date:** _____

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

Home #: _____ **Work #:** _____ **Cell #:** _____

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

Birth Date: ____/____/_____ **Age:** _____ **Social Security #:** _____--_____--_____

Insurance Name: _____ **Guarantors (if not self):** _____

Preferred language: *English Spanish* **Occupation:** _____

Sex: *M F* **Circle one:** *single married widowed divorced legally separated partnered unknown*

Spouse's Name: _____ **Spouse's Occupation:** _____

Names & Ages of Children: _____

Ethnicity: (check all that apply)

- o *White*
- o *Black/African American*
- o *American Indian/Alaskan Native*
- o *Hispanic Latino*
- o *Asian*
- o *Declined*

Race: (check one)

- o *Hispanic/Latino*
- o *Non Hispanic/Latino*
- o *Declined*

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:

___Headaches	___Carpal Tunnel	___Asthma	___Digestive Problems
___Neck Pain	___Problem Sleeping	___Vertigo	___Pain Between Shoulder Blades
___Mid-Back Pain	___Ringing in Ears	___Anxiety	___Shortness of Breath
___Low-Back Pain	___Loss of Balance	___Cancer	___Tension across top of shoulders
___Sciatic Pain	___High Blood pressure	___Allergies	___Numbness in Arms/legs
___Leg or Hip pain	___Weight Trouble	___Dizziness	___Menstrual Pain
___Shoulder pain	___Arm pain	___Depression	___Low Energy/Fatigue

___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)

Physical Stress		**Emotional Stress**		**Chemical Stress**	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip/Fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	2nd Hand Smoke	C T A N
Sports Injury	C T A N	Money	C T A N	Caffeine	C T A N
Physical Abuse	C T A N	Fast paced Life	C T A N	Artificial Sweeteners	C T A N
Work Injury	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Poor Posture	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach sleeper	C T A N	Procrastinator	C T A N	Poor Diet	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				

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:

_____
_____
_____

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www.centerforlifechiropractic.com
Dr. Jason A. Friedman, D.C.

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. I give Center For Life Chiropractic, P.C. permission to adjust me within an open-air room where other people are also being adjusted. I am aware that other persons in the office may overhear some of my health information and casual conversation during the course of care. Should I need to speak with the doctors at any time in private: the staff will provide a room for these conversations. I also consent to signing the guest book every time and understand that it may be in view of others.

4. 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.

5. 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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