Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ ▢ Male ▢ Female Today’s Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you a student? ▢ Yes ▢ No

▢ Single ▢ Married ▢ Divorced ▢ Widowed Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children: \_\_\_\_\_\_\_\_

Names, Ages, & gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnant?: ▢ Yes ▢ No

Have you ever been in the military? ▢ Yes ▢ No Who can we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THE OFFICE



Health Concern: Rate of severity When did Have you had the Did this begin Are symptoms

(List according to 0 = no pain this problem problem before? with an injury? Constant (C)

Severity) 10 = unbearable start? If so, when? Intermittent (I)?

1st: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3rd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4th: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU SEEN OTHER DOCTORS FOR THESE CONDITIONS? ▢ Yes ▢ No

▢ CHIROPRACTOR ▢ MEDICAL DOCTOR ▢ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO AND WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Mark “P” For In The Past OR Mark “C” For Currently Have:**

\_\_\_ Headaches \_\_\_ Ear Infections \_\_\_ Sinus Issues \_\_\_ Kidney Problems \_\_\_ Sexual Dysfunction

\_\_\_ Migraines \_\_\_ Hearing Loss \_\_\_ Frequent Colds \_\_\_ Bladder Problems \_\_\_ Sleep Problems

\_\_\_ Jaw/TMJ Pain \_\_\_ Ringing in the Ears \_\_\_ Thyroid Issues \_\_\_ Menstrual Problems \_\_\_ Tight/Sore Muscles

\_\_\_ Neck Pain \_\_\_ Dizziness \_\_\_ Asthma \_\_\_ Prostate Problems \_\_\_ Sports Injury

\_\_\_ Shoulder Pain \_\_\_ Loss of Energy \_\_\_ Chest Pain \_\_\_ Infertility \_\_\_ Sciatica

\_\_\_ Arm Pain \_\_\_ Nervousness \_\_\_ Heart Problems \_\_\_ Fibromyalgia \_\_\_ Arthritis/Joint Pain

\_\_\_ Upper Back Pain \_\_\_ Double/Blurry Vision \_\_\_ Nausea \_\_\_ Epilepsy/Convulsions \_\_\_ GERD/Gastric Reflux

\_\_\_ Mid Back Pain \_\_\_ Anxiety \_\_\_ Ulcers \_\_\_ Tremors \_\_\_ Numb/Tingling in Arms/Hands

\_\_\_ Lower Back Pain \_\_\_ ADD/ADHD \_\_\_ Digestive Issues \_\_\_ Disc Problems \_\_\_ Numb/Tingling in Legs/Feet

\_\_\_ Hip/Leg Pain \_\_\_ Loss of Balance \_\_\_ Diarrhea \_\_\_ Scoliosis \_\_\_ Stomach Problems

\_\_\_ Knee Pain \_\_\_ Depression \_\_\_ Constipation \_\_\_ Poor Posture \_\_\_ High/Low Blood Pressure

\_\_\_ Foot Pain \_\_\_ Allergies \_\_\_ Bed Wetting \_\_\_ Skin Problems \_\_\_ Difficulty Breathing

Other(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

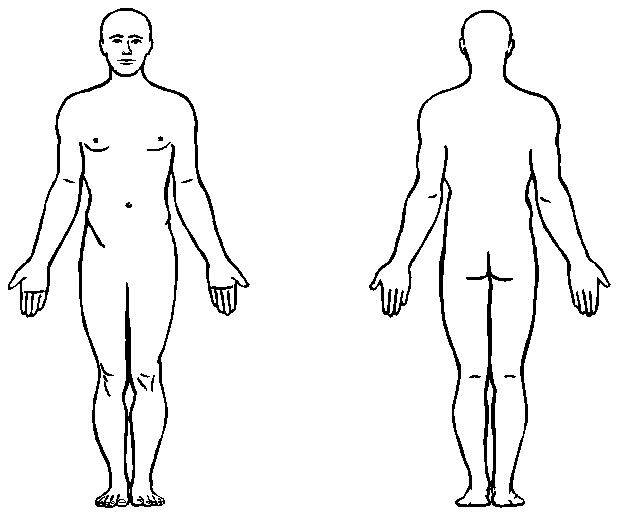
**Please Mark “P” For In The Past OR Mark “C” For Currently Have:**

\_\_\_ Stroke \_\_\_ Cancer \_\_\_ Heart Attack \_\_\_ Spinal Surgery \_\_\_ Diabetes

\_\_\_ Spinal Bone Fracture \_\_\_ Scoliosis \_\_\_ Arthritis \_\_\_ Seizures Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE MARK the areas on the diagram with the following LETTER(S) to describe your symptoms:**

R=Radiating B=Burning D=Dull A=Aching N=Numbness S=Sharp/Stabbing T=Tingling

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When is/are the problem(s) at its worst? AM PM Mid-Day Late PM

List all surgical operations & years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other injuries to your spine, minor or major, that the doctor should know about:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all over the counter & prescription medications you are on, & the reason for each:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been in an auto accident? List all: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been knocked unconscious? ▢ Yes ▢ No Fractured A Bone? ▢ Yes ▢ No

If yes to either of the above, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quadruple Visual Analogue Scale**

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

*EXAMPLE:* No pain Back Pain Headaches Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

1. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

1. What is your pain level at its BEST? (How close to 0 is your pain at its best?) 0 1 2 3 4 5 6 7 8 9 10

* What percentage of your awake hours is your pain at its best? \_\_\_\_\_\_%

1. What is your pain level at its WORST? (How close to 10 is your pain at its worst?)

0 1 2 3 4 5 6 7 8 9 10

* What percentage of your awake hours is your pain at its worst? \_\_\_\_\_\_%

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FOR OFFICE USE: Q1\_\_\_\_\_+ Q2\_\_\_\_\_+ Q4\_\_\_\_\_=\_\_\_\_\_\_/3x10=\_\_\_\_\_

**Activities Of Life**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITY: EFFECT:**

Sit to Stand ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Carry Groceries ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Climbing Stairs ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Pet Care ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Driving ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Extended Computer Use ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Household Chores ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Lifting Children ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Dressing ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Sexual Activities ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Sleep ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Static Sitting ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Static Standing ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Walking ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Washing/Bathing/Shaving ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Sweeping/Vacuuming ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Yard work ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Garbage ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Concentration (Reading) ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ▢ No Effect ▢ Painful (can do) ▢ Painful (limits) ▢ Unable to Perform

**WHAT ARE YOU HOPING TO ACHIEVE WHILE UNDER CARE?**

HEALTH GOAL EXAMPLE: Get rid of my headaches. SIGNIFICANCE OF GOAL: I want to play with my kids without pain.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME HERE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SIGNATURE OR GUARDIAN SIGNATURE DATE

**WRITTEN CONSENT FOR A MINOR** *IF THIS HEALTH PROFILE IS FOR A MINOR, PLEASE FILL OUT AND SIGN BELOW*

NAME OF PATIENT WHO IS A MINOR/CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE DR. ROGER BRADY AND ANY AND ALL OPTIMAL LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY OPTIMAL LIFE CHIROPRACTIC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS SIGNATURE (OFFICE STAFF) DATE

**TERMS OF ACCEPTANCE**

To provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic.

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
3. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region, or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
5. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic .
7. We invite you to speak frankly to the doctor or any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment .

*By my signature below, I have read and fully understand the above statements.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician’s certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**X-RAY AUTHORIZATION** FILE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.

WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR DAY OF OPERATION.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS.

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF OPTIMAL LIFE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME HERE DATE OF BIRTH

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**FEMALE PATIENT ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT OPTIMAL LIFE CHIROPRACTIC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

*------------------ DO NOT WRITE BELOW THIS LINE ------------------*

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Lat Cervical       ☐ Flex/Ext    CM        Kvp Time      MAS  ☐10-11    ☐78    ☐1/24      12.5  ☐12-13    ☐        ☐1/20       15  ☐14-15                ☐1/15       20  ☐16-17                ☐1/10     30                                ☐2/15    40  MA 300       Size 8x10 | ☐ Lower Cervical    CM        Kvp Time      MAS  ☐14-15    ☐70    ☐1/10       20  ☐16-17    ☐        ☐2/15       30  ☐18-19                ☐3/20       40  ☐20-21                ☐2/10       50  ☐22-23  MA 300       Size 8x10 | ☐ Lateral Thoracic    CM         Kvp Time     MAS  ☐22-23    ☐80     ☐1/15      20  ☐24-25    ☐         ☐1/10      30  ☐26-27                 ☐2/15      40  ☐28-29                 ☐2/10      50  ☐30-31                 ☐1/4        75  ☐32-33                 ☐3/10      90  ☐34-35                 ☐2/5       120  ☐36-37                 ☐1/2       150  MHA 300       Size14x17 | ☐ A-P Thoracic    CM         Kvp Time     MAS  ☐16-17    ☐75     ☐1/20      17  ☐18-19    ☐         ☐1/15      22  ☐20-21                 ☐1/10      30  ☐22-23                 ☐2/15      40  ☐24-25                 ☐2/10      50  ☐26-27                 ☐1/4        75  ☐28-29                 ☐3/10      90  ☐30-31                 ☐2/5       120  MA 300       Size14x17 |
| ☐ APOM    CM        Kvp Time     MAS  ☐14-15    ☐70     ☐1/10      20  ☐16-17    ☐         ☐2/15      30  ☐18-19                 ☐3/20      40  ☐20-21                 ☐2/10      50  ☐22-23  MA 300       Size 8x10 | Other  View  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    CM\_\_\_\_\_\_\_\_\_  Kvp \_\_\_\_\_\_\_\_  MAS\_\_\_\_\_\_\_\_ MA\_\_\_\_\_\_\_\_  Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Lateral Lumbar    CM       Kvp Time     MAS  ☐26-27    ☐88     ☐2/10      30  ☐28-29    ☐90     ☐1/4        40  ☐30-31    ☐92     ☐3/10      50  ☐32-33    ☐94     ☐2/5        70  ☐34-35    ☐96     ☐1/2        90  ☐36-37    ☐         ☐3/5       120  ☐38-39                 ☐4/5       160  ☐40-41                 ☐1          200  ☐42-43                 ☐1 1/2                                 ☐2  MA 200       Size 14x17 | ☐ A-P Lumbar    CM         Kvp Time     MAS  ☐20-21    ☐76     ☐1/15      40  ☐22-23    ☐78     ☐1/10      50  ☐24-25    ☐80     ☐2/15      75  ☐26-27    ☐         ☐2/10      90  ☐28-29                 ☐1/4       120  ☐30-31                 ☐3/10     150  ☐32-33                 ☐2/5       120  ☐34-35                 ☐1/2       170  ☐36-37                 ☐3/5       210  ☐38-39                 ☐4/5  ☐40-41                 ☐1  ☐42-43                 ☐1 1/2                                  ☐2  MA 300       Size 14x17 |
| Sex: M / F  NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| CA Initials:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAMILY HEALTH HISTORY**

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR REVIEW.

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PLEASE PRINT NAME HERE DATE

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| --- | --- | --- | --- | --- | --- |
| **CONDITION** | **SPOUSE** | **SON** | **DAUGHTER** | **MOTHER** | **FATHER** |
| HEADACHES |  |  |  |  |  |
| NECK PAIN |  |  |  |  |  |
| JAW PAIN/TMJ |  |  |  |  |  |
| SHOULDER PAIN |  |  |  |  |  |
| BACK PAIN |  |  |  |  |  |
| HIP/LEG PAIN |  |  |  |  |  |
| ARTHRITIS/JOINT PAIN |  |  |  |  |  |
| EAR INFECTIONS |  |  |  |  |  |
| HEARING LOSS |  |  |  |  |  |
| DIZZINESS |  |  |  |  |  |
| LOSS OF ENERGY |  |  |  |  |  |
| NERVOUSNESS |  |  |  |  |  |
| BLURRED/DOUBLE VISION |  |  |  |  |  |
| ANXIETY |  |  |  |  |  |
| ADD/ADHD |  |  |  |  |  |
| DEPRESSION |  |  |  |  |  |
| ALLERGIES |  |  |  |  |  |
| SINUS ISSUES |  |  |  |  |  |
| THYROID PROBLEMS |  |  |  |  |  |
| ASTHMA |  |  |  |  |  |
| BREATHING PROBLEMS |  |  |  |  |  |
| HEART PROBLEMS |  |  |  |  |  |
| HIGH/LOW BLOOD PRESSURE |  |  |  |  |  |
| STOMACH PROBLEMS |  |  |  |  |  |
| BED WETTING |  |  |  |  |  |
| INFERTILITY |  |  |  |  |  |
| SCIATICA |  |  |  |  |  |
| FIBROMYALGIA |  |  |  |  |  |
| POOR POSTURE |  |  |  |  |  |
| SLEEP PROBLEMS |  |  |  |  |  |
| STROKE |  |  |  |  |  |
| CANCER |  |  |  |  |  |
| HEART DISEASE |  |  |  |  |  |
| DIABETES |  |  |  |  |  |
| ARTHRITIS |  |  |  |  |  |
| ALZHEIMERS |  |  |  |  |  |