SHARE ZONE HEALING WITH YOUR FRIENDS AND FAMILY

LAST NAME_____ FIRST NAME _____ MIDDLE _____ ❑ Male ❑ Female

ADDRESS _____ SS# _____BIRTHDATE _____AGE _____

CITY _____STATE_____ZIP_____ DRIVER'S LICENSE#_____HEIGHT _____WEIGHT _____

❑ SINGLE ❑ MARRIED ❑ OTHER_____ # OF CHILDREN _____ SPOUSE'S NAME _____

OCCUPATION _____ SPOUSE'S OCCUPATION _____

EMPLOYER _____ EMPLOYER _____

PHONE (hm)( )_____ (wk)( )_____ Contact in case of emergency _____

E-MAIL _____ Phone (hm) ( )_____ (wk)( )_____

REFERRED BY _____ DO YOU HAVE HEALTH INSURANCE? ❑ YES ❑ NO

What is your major complaint?_____

_____

Other complaints? _____

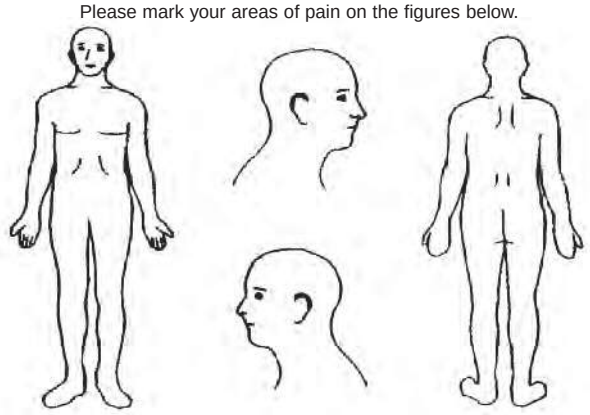
How long have you had this condition?_____ Have you had this or a similar condition in the past? _____

Did your condition occur while at work? ❑ Yes ❑ No When? _____

Is this condition the result of a car accident? ❑ Yes ❑ No When? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and Goes_____

Please mark your areas of pain on the figures below.



_____ Neck Problems	_____ Sore Muscles	_____ Allergies
_____ Shoulder Problems	_____ Walking Problems	_____ Hay Fever
_____ Arthritis	_____ Broken Bones	_____ Asthma
_____ Arm Problems	_____ Muscle Cramps	_____ Shortness of Breath
_____ Numbness-Arms	_____ Weak Muscles	_____ Eczema
_____ Pain Between Shoulders	_____ Headaches	_____ Shingles
_____ Low Back Problems	_____ Dizziness	_____ Nausea
_____ Leg Problems	_____ Fainting	_____ Poor Digestion
_____ Numbness-Legs	_____ Forgetfulness	_____ Ulcers
_____ Loss of Feeling	_____ Depression	_____ Heart Burn
_____ Stiff Joints	_____ Vision Problems	_____ Diarrhea
_____ Painful Joints	_____ Ear Pain/Noises	_____ Constipation
_____ Restricts Daily Activities	_____ Ear Infections	_____ Kidney Infection
_____ Restricts Regular Exercise	_____ Hearing Loss	_____ Menstrual Cramps
_____ Cancer	_____ Frequent Colds	_____ Diabetes
_____ Heart Disease	_____ Blood Pressure High/Low	_____ Tiredness/Fatigue
_____ Osteoporosis	_____ Fibromyalgia	Other_____

This is a new/old illness. It was/was not treated before.

If treated before, what was done? _____

Name of Doctors:_____

Have you ever had surgery or been hospitalized? ❑ Yes ❑ No

List Surgeries: _____

Have you ever had Chiropractic care before? ❑ Yes ❑ No

Name of Doctor _____ Date _____

Last time you had spinal X-rays or other X-rays: _____

Medications you now take: _____

From birth to present please list by date/describe.

1) Car Accidents _____

_____

_____

2) Falls/Injuries (including Sports)_____

_____

_____

3) Other _____

_____

_____

(FOR DOCTORS USE ONLY)

Insurance Co. _____

Secondary_____

Ded. _____M_____NM_____

Benefits %_____ x-r %_____

_____

Visits/CY_____

DME:_____

Special provisions_____

_____

_____

C.P. W _____

M _____

P.V._____

Health Study scheduled:_____

Health Study attended: _____

PATIENT'S SCHEDULE
1
2
3
4
5
6
CASES REFERRED BY THIS PATIENT (Names and Dates)
1
2
3
4
5
6

PATIENT REPORTING

0 - NO SYMPTOMS	9 - 10% IMPROVEMENT
1 - 90% IMPROVEMENT	10 - NO IMPROVEMENT - START
2 - 80% IMPROVEMENT	11 - 10% WORSE
3 - 70% IMPROVEMENT	12 - 25% WORSE
4 - 60% IMPROVEMENT	13 - 50% WORSE
5 - 50% IMPROVEMENT	14 - 75% WORSE
6 - 40% IMPROVEMENT	15 - 100% WORSE
7 - 30% IMPROVEMENT	16 - NEW CONDITION
8 - 20% IMPROVEMENT	17 - REAGGRAVATED OLD CONDITION

D.I._____ D.O._____

E1	E2	E3	E4
C1	C13	T9	L6
C2	C14	T10	L7
C3	C15	T11	L8
C4	C19	T12	L9
C5	T1	T13	L10
C6	T2	T14	L11
C7	T3	L15	L12
C8	T4	L1	L13
C9	T5	L2	L14
C10	T6	L3	L15
C11	T7	L4	
C12	T8	L5	SD

ADDITIONAL

❑ Laws of Life _____

❑ Inner Klean Diet _____

❑ Patient Testimonial _____

❑ Handouts:_____

_____

❑ Exercises:_____

_____

❑ Other:

_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it.

Adjustment: An 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.

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 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.

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 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 that you seek the services of a 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 method is specific adjusting to correct vertebral subluxations.

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

_____ _____
Signature *Date*

Acknowledgement of Receipt of "Notice of Privacy Practices"

I, _____ hereby acknowledge that I have been offered a copy of this chiropractic practice's "Notice of Privacy Practices." I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended notice of privacy practices.

_____ _____
Signature *Date*

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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, whether signatories to this form or not.

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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____