Welcome to Springfield Holistic Wellness

Thank you for choosing our office for your health care needs. We are committed to providing you and your family with the highest quality of corrective and wellness care available so that you can enjoy an active, healthy life.

When a person seeks health care in our office and we accept that person for such care, it is essential for all of us to be working towards the same objective. It is important for you to understand that **we do not diagnose or treat disease.** We have only one goal in our office: **to optimize your body's expression of its innate health potential.** This type of care typically takes longer than just suppressing a symptom with a toxic drug. Whether you are seeking chiropractic care, dietary counseling, whole food nutrition supplementation, acupuncture, therapeutic massage, or any combination of these healing modalities, it is important that each individual understand our goals as well as the methods that will be employed in pursuit of these goals. This will prevent any confusion or misunderstanding throughout the course of your care. Towards that end, here are some terms as defined in our office:

Health: A state of **optimal** physical, mental and social well-being, and **not merely the absence of symptoms or disease**.

Chiropractic Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae (bones) in the spinal column which can not only cause pain, but which can also alter nerve function resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractic Adjustment: A chiropractic adjustment is the specific application of a low force, high amplitude (light and quick) impulse, usually to the back or neck, used to facilitate the body's correction of vertebral subluxation, thereby alleviating nervous system interference. As with any healthcare modality, chiropractic adjustment carries its own inherent risks. The risks associated with chiropractic care include, but are not limited to, bruising, sprains and strains, disc injuries, neurologic events, and fractures. While these occurrences are rare, we feel it is important to our relationship with our practice members that you are made aware of these possibilities.

Nutrition Supplementation: We may incorporate whole food/herbal supplementation into your care plan in pursuit of giving your body the nutrients it needs to optimize its function. Nutrition supplementation does carry some minor risks from stomach upset to allergic reaction. Again though exceedingly rare, you should be informed of these possibilities. **While we do not diagnose or treat disease**, our aim with whole food/herbal nutrition supplementation is to provide your body with the genuine replacement parts it needs in order to express your best possible health. **Our only practice objective is to optimize the expression of your body's innate intelligence.**

Acupuncture: Acupuncture is a generally safe method of treatment, but it may have some side effects including minor bleeding or bruising and/or numbness or tingling near the needling sites that may last a few days. Dizziness or fainting are also rare, but possible side effects. Unusual risks of acupuncture include infection, nerve damage and organ puncture. Some possible side effects of taking herbs used in Chinese Medicine are stomach upset, headache, rashes, and tingling of the tongue.

Health Changes: If you become pregnant or have any other change to your health status while under care in our office, it is your responsibility to notify us of these changes so we can, if need be, modify your care plan accordingly.

I have read and fully understand the above statements. I have had the opportunity to ask any questions I may have.

_____ _____

(Signature) (Date)

_____ _____

(Print Name) Relationship to Pt.

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Please Print Clearly Today's Date: _____

Name: _____ I prefer to be called: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ DOB: ___/___/___ Age: _____

Occupation: _____ Whom may we thank for referring you? _____

Single Married Divorced Widowed Email Address: _____

Your Current Concern(s): _____

_____

How long have you been dealing with this issue? _____ Date of Onset: ___/____/____

How did your problem begin? _____

Rate the severity of your symptoms: 0 (none) – 10 (emergency): _____

How often are your symptoms present? 25% or less 26-50% 51-80% 81-100%

Any time of day when symptoms are better or worse? _____

Does anything make your symptoms better or worse? _____

Since this episode began, is your problem: Getting Better Staying the Same Getting Worse

Does your current complaint interfere with activities of daily living (sleeping, working, shopping, etc.)? Yes No

If yes, explain: _____

_____

Have you been treated for this episode or a previous episode of this same problem? Yes No

If yes, name and type of provider and when treated: _____

_____

_____

List **all** prescription and over-the-counter medications (with dosage if known) that you are currently taking:

_____

_____

List **all** vitamin, mineral and herbal supplements (with dosage if known) that you are currently taking:

_____

_____

Exercise: None 1-2 days/week 3-4 days/ week 5-7 days/ week Type: _____

Lifestyle:	Tobacco use:	Past	Present	Occasional	Moderate	Heavy
	Alcohol Use	Past	Present	Occasional	Moderate	Heavy
	Coffee, Tea, Soda	Past	Present	Occasional	Moderate	Heavy
	Stress	Past	Present	Occasional	Moderate	Heavy

Family Medical History – Please list any medical conditions (present or past) in your grandparents, parents or siblings (living or deceased):_____

_____

_____

Do you have or have you experienced any of the following:

☐Neck Pain	☐Osteoporosis	☐Kidney/Urinary/Bladder	☐Anemia/Blood Disorder
☐Lower Back Pain	☐Headaches/Migraines	☐Excess/Difficult Urination	☐ Dizziness/Ringing in Ears
☐Upper Back Pain	☐Arthritis/Stiff Joints	☐Liver/Gallbladder	☐Diabetes – Type I/Type II
☐Shoulder Pain	☐High/Low Blood Pressure	☐Breast Soreness/Lumps	☐Diarrhea/Constipation
☐Arm/Elbow Pain	☐Heart Condition/Pacemaker	☐Gynecological Disorder	☐Prostate Condition
☐Wrist/Hand Pain	☐Stroke/Vascular Disease	☐Pregnancy	☐Psychiatric Condition
☐Hip/Leg Pain	☐Respiratory Condition	☐Menstrual Problems	☐Plastic Surgery
☐Ankle/Foot Pain	☐Allergies/Asthma	☐Gastrointestinal Condition	☐Cancer/Leukemia
☐Scoliosis	☐Fainting/Seizures/Epilepsy	☐Excess Weight Loss/Gain	☐Sexual Disease/HIV+/AIDS
☐Disc Degeneration	☐Skin Condition	☐Sinus Condition	☐Eye/Ear/Nose Condition

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I (or my minor child) ever have a change in health status.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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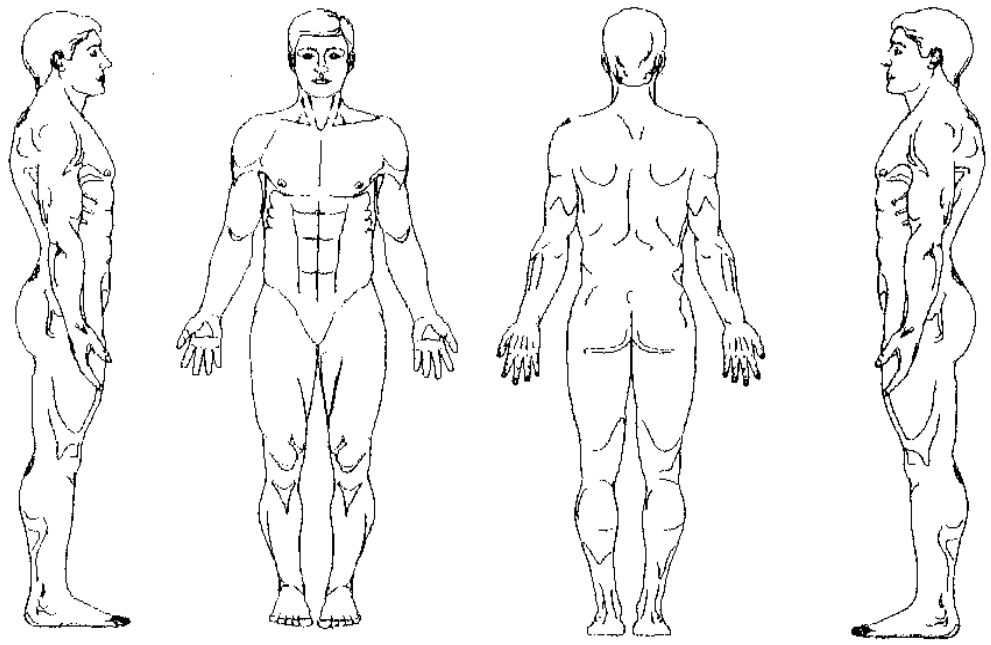
Use the symbols below to locate & describe your condition:

A = Aching N = Numbness P = Pins & Needles B = Burning S = Stabbing



As a result of my care, I would like to (please check all that apply):

☐ Feel better quickly ☐ Be healthier by keeping my nervous system healthy

☐ Live a healthier lifestyle ☐ Help my body heal itself

_____ _____

Signature Date

ASSIGNMENT OF BENEFITS

I certify that I, and/or my dependents, assign directly to Springfield Holistic Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Springfield Holistic Wellness may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient Signature Date

_____

Print Name