



Name: _____ Home Phone: _____

(Please Print)

Cell Phone: _____

Referred By: _____ Email: _____

Complete Address: _____

City: _____ State: _____ Zip: _____ SSN: _____

Date of Birth: _____ Age: _____ Occupation: _____

Name of Spouse: _____ Number of Children: _____

Hobbies & Interests (What do you do for fun?) _____

Have you been to a Chiropractor before? Yes No

If yes, who and when: _____

Have you been seen by a medical doctor for any reason in the last year? Yes No

If yes, Explain: _____

What brings you to the office today? _____

If you have no specific problem but are here to have your spine checked for vertebral subluxations, check here _____

Have you had any surgeries, falls, accidents or injuries? If yes, please list what and when: _____

List any complications during or after your own birth. Include forceps delivery, Caesarean, etc.: _____

How would you rate your (circle): Diet: Poor Good Excellent

Rest: Poor Good Excellent

Exercise: Poor Good Excellent

Your last visit to a Chiropractor was (circle one): Never 3 Months or More Less than 3 Months

TERMS OF ACCEPTANCE

Chiropractic has only one goal that is to remove nerve interference caused by a misalignment of spinal bones. It is important that you understand that diagnosing and treating conditions along with removing pain is not the objective, but rather removing nerve interference through specific Chiropractic care is the goal. Although this office may relieve you of pain, maintaining your health through regular spinal adjustments is our primary concern.

I therefore accept Chiropractic Care on this basis.

Signature _____ Date _____

REASON FOR CONSULTING THIS OFFICE (Please check one of the following three reasons)

_____ I have no special problem; I understand the role of chiropractic in my general well being.

_____ I have the symptom of a physical problem and I want to see if chiropractic will enable my body to work better. I am also interested in learning about the role of chiropractic in improving my expression of life and that of my family.

_____ I have a symptom and I am only interested in relief from it.

On a scale of 1 to 10 (with 10 being the highest) what number best describes your occupational/personal life stress? _____

On a scale of 1 to 10 (with 10 being the highest) what is your commitment level to your health and staying healthy? _____

What do you regularly do (or plan to do) to improve your life and health? _____

Welcome to Guse Chiropractic

When a person seeks the services of a chiropractor, it is essential that they fully understand the objectives of that particular Chiropractor.

We have one goal at Guse Chiropractic, that is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bone of the spine), which interfere with the function of these nerve pathways, are called **vertebral subluxations**. Subluxations are caused by many of the things you do everyday and keep your whole body from functioning properly. It is our absolute conviction that **the body is always better off without this interference**.

Consequently, the objective of Guse Chiropractic is to provide a chiropractic adjustment to correct subluxations thereby restoring normal nerve function. It is not the objective or intention of Guse Chiropractic to fix, treat or attempt to cure any physical, mental or emotional ailments or to give advice about any ailments. **With a proper nerve supply your whole body is better able to reach its full potential and to express more life.**

The information we receive from you is important. We ask only that which is necessary for your care here at Guse Chiropractic. Please fill out the forms completely and to the best of your ability. If you have any questions or if there is any information you feel we should know, please mention it to the chiropractor.

I, _____, have read the above, understand it fully, and choose to receive chiropractic for myself and family members (listed below) on this basis.

Date: _____

Consent to Care For a Minor Child

I hereby authorize Dr. Shawn Guse and whomever he may designate as assistants to administer Chiropractic care as he deems necessary to my child/minor/ward.

Name of Minor: _____

Guardian Signature: _____

Date: _____