Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Age) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT… To help us best serve you, please answer the following questions completely and to the best of your ability…**

**What is your main complaint and reason for visiting our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How long have you been experiencing your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_ Days Weeks Months Years

Is your complaint a result of a work-related injury, motor vehicle accident or trauma of any kind? YES NO

If yes, please put date and briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any pain, numbness/tingling or pins/needles in any of your extremities? YES NO

If YES, please briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any pain with COUGHING, SNEEZING or with BOWEL MOVEMENTS? YES NO

How does your problem affect your life and daily routine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms? Please circle: Constantly Frequently Sometimes Rarely

Please list anything that aggravates your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list anything that helps your symptoms (exercises, meds, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate the severity of your problem or pain? (min) 1 2 3 4 5 6 7 8 9 10 (severe)

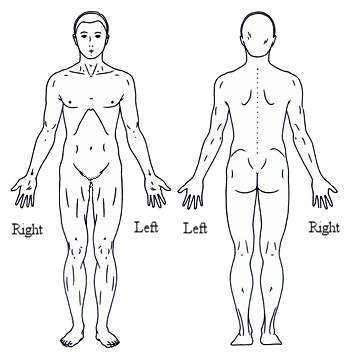
Is your condition getting worse? 􀀀 No 􀀀 Yes, how so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen anyone for this problem in the past? NO YES, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received any treatment in the past that was successful? NO YES, please share… \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any tests you have had regarding your current complaint: X-Rays MRI CT Scan EMG Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Using the symbols below, mark on the pictures where**

**you have any symptoms...**

Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ^ ^ ^

**Nerve System balance is an important part of a healthy functioning body. Poor nerve system balance can lead to sickness and disease and a host of symptoms. Please mark any of the following symptoms you may be experiencing to help us assess your nerve system balance. If you take medication for any of the following symptoms, please mark the symptom.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Poor Digestion / Decrease Salvation (dry mouth) |  | Increased Bowels sounds / Rapid digestion |
|  | Constipation |  | Hyperactive bowel / Colicky |
|  | Anxiety |  | Incontinence |
|  | Increased Breathing / Increased Heart Rate |  | Dizzy / Loss of balance upon standing |
|  | High Blood Pressure |  | Loves to sleep / Doesn’t want to get out of bed in A.M. |
|  | Poor Sleep Quality / Restless |  | Doesn’t Sweat / Decreased Perspiration |
|  | Night Sweats |  | Increased Libido |
|  | Orgasm Quality Decline |  | Slow Heart Rate / Low Blood Pressure |
|  | Low Libido (sex drive) |  | Depression |
|  | Waking Unrested |  | Increased mucus secretions / Allergies |
|  | Nervousness / Restless / Agitated easily |  | Increased gag reflex |
|  | Jittery |  | Diagnosed with an Auto-immune condition |
|  | Increased muscle tension & stress |  | Afternoon Napper |
|  | Chronic Inflammation / Pain |  | Slow in the A.M. / Hits the snooze button several times |
|  | Increased susceptibility to colds & infections |  | Heart Attack / T.I.A. |
|  | Can’t shut off brain and relax |  | Cold Hands / Cold Feet |
|  | Sensitive to Light / Light bothers your eyes |  | Cancer - Type: |
|  | Migraines / Headaches |  |  |
|  | Diabetes |  |  |
|  | Menstrual Challenges / Hot Flashes / Cramps |  |  |

**If is important to know that organ weakness or dysfunction can affect the nerve system causing visceral-somatic pain syndromes (pain stemming from an organ that refers pain to the musculoskeletal system). Please mark any of the following symptoms that you may experience or have been troubled with in the past… Please circle any symptoms that apply.**

􀀀 Digestive Trouble of any kind (this includes heartburn, indigestion, bloating, gas, stomach aches, infrequent bowel movements etc.)

􀀀 Immune Challenges (this includes frequent colds/infections, chronic allergies, sinus trouble, chronic cough, dizziness, etc.)

􀀀 Kidney/Urinary/Bladder Challenges (this includes UTI’s and infections, incontinence, prostate trouble (men), yeast infections, etc.)

􀀀 Heart / Lung Challenges (this includes chronic cough, infections, asthma, emphysema, A-Fib, heart palpitations, etc.)

􀀀 Please note if you have had any pain / trouble / challenges with any of the following muscles or joints (includes surgeries): TMJ

Hamstrings Quads Achilles Calves Knees Ankles Hips IT-Bands Elbows Wrists Shoulders Between Shldrs.

Are you under medical care for any condition(s)? No Yes, please list condition(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever had any type of surgery? No Yes, please list and include the year it was performed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark if there is any Family History of:**

Heart Disease Arthritis Cancer Diabetes Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s side O O O O O

Mother’s side O O O O O

**EXPERIENCE WITH CHIROPRACTIC AND HOLISTIC WELLNESS CARE**

Have you seen a Chiropractor or Holistic Wellness doctor in the past? 􀀀 No 􀀀 Yes, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your reason for seeking care? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have seen a Chiropractor or Holistic Wellness doctor in the past, how did you respond?

􀀀 Well 􀀀 Not as good as I had hoped 􀀀 Not Well

Did your previous chiropractic experience take before and after x-rays? 􀀀 Yes 􀀀 No

***Do you take any supplements (i.e. vitamins, minerals, herbs)?***

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

***Please list any medication you are currently taking and why?***

|  |  |
| --- | --- |
| **MEDICATION** | **REASON FOR MEDICATION** |
| 1 |  |
| 2 |  |
| 3 |  |

Is there any other information not mentioned here-in that you would like the doctor to be aware of or informed? No Yes, if yes please explain… \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Goals… We offer many different types of services here in our office, all geared toward improving the health and function of the body as a whole. To be sure we help you the best we can please tell us what your goals are and what you are looking for here at our office. (Mark all that apply.)**

O I would like to eliminate my pain / symptoms O I would like to improve my Health and Function

O I would like to learn why I am experiencing my symptoms O I would like to improve my posture

O I would like to improve my eating habits and nutrition O I would like to improve my athletic performance

O I would like to improve my energy and well-being O I would like to improve my digestive health

O I would like to improve my hormone health O I would like to eat right and lose weight naturally

O other:

***I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.***

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO CARE**

I do hereby authorize the doctors of Power of LIFE Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. Furthermore, I authorize and agree to allow the Doctor of Chiropractic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function. I will have an opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures related to my health care. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**

**In Case of Emergency**

Name Relationship

Work Phone ( )

Home Phone ( )

Cell Phone ( )

**Pregnancy Release**

This is to certify that I am not pregnant. By signing below the above doctor and his associates have my permission to perform/request an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination, including x-rays, if deemed necessary by the doctor and any care recommended thereafter.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA-ACKNOWLEDGEMENT OF RECEIPT**

**Notice of Privacy Practices**

We at Power of Life, LLC are required by law to maintain the privacy of and provide individuals with a Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

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

Signature of patient or patient’s representative/parent Date

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

Printed name of patient or patient’s representative/parent Relationship to Patient

**Health Insurance Assignment of Benefits**

**We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this office.** In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case, will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Your Clinic Name is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event, we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances, we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

By signing below, I understand the terms and conditions stated above

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date / /

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