

Today's Date: _____



MEMBER INFORMATION

Name: _____ Date of Birth: _____

Email: _____ Cell Phone: _____

Street Address: _____

City / State / Zip: _____

Single / Married / Divorced / Engaged – Spouse/Partner's Name: _____

Children(s) Names, Ages & Biological Gender: _____

Who may we thank for referring you? _____

What do you do for work? _____ Employer: _____

HEALTH INFORMATION

Why are you seeking help today? _____

How long has this been going on? _____

What have you done to try and solve this problem? _____

What are your additional health goals (if any)? _____

How long do you think it will take to achieve your health goals? Why? _____

When was the last time you felt at your best? (How long ago?) _____

Please share additional reasons you want to improve your health? _____

Past chiropractic experience? (please describe your experience and results) _____

Did they measure and monitor the function of your nervous system? Yes / No

Family health history: _____

Medications: (What and what for?) _____

List previous surgeries and year performed: _____

LIFESTYLE INFORMATION

Do you exercise? Yes / No If yes, how often? _____

Tobacco? Yes / No If yes, how often? _____

Consume Alcohol? Yes / No If yes, how often? _____

*** How much water do you think you drink per day? _____

Do you believe that early detection will give you a better chance of preventing future health problems?

Yes / No

Please describe the purpose and importance of your spine and nerve system (there are no wrong answers!)

Please check all of the following health concerns that you have experienced

Past (P) Current (C) or both

ADD/ADHD	<input type="checkbox"/> P <input type="checkbox"/> C	Heartburn/Reflux	<input type="checkbox"/> P <input type="checkbox"/> C
Allergies	<input type="checkbox"/> P <input type="checkbox"/> C	Heart condition	<input type="checkbox"/> P <input type="checkbox"/> C
Anxiety	<input type="checkbox"/> P <input type="checkbox"/> C	Immune system disorder	<input type="checkbox"/> P <input type="checkbox"/> C
Arthritis	<input type="checkbox"/> P <input type="checkbox"/> C	Infertility	<input type="checkbox"/> P <input type="checkbox"/> C
Asthma	<input type="checkbox"/> P <input type="checkbox"/> C	Kidney disease	<input type="checkbox"/> P <input type="checkbox"/> C
Back pain	<input type="checkbox"/> P <input type="checkbox"/> C	Menstrual cramps	<input type="checkbox"/> P <input type="checkbox"/> C
Bladder problems	<input type="checkbox"/> P <input type="checkbox"/> C	Migraines	<input type="checkbox"/> P <input type="checkbox"/> C
Cancer	<input type="checkbox"/> P <input type="checkbox"/> C	Mood swings	<input type="checkbox"/> P <input type="checkbox"/> C
Circulatory/Vascular issues	<input type="checkbox"/> P <input type="checkbox"/> C	Neck pain	<input type="checkbox"/> P <input type="checkbox"/> C
Depression	<input type="checkbox"/> P <input type="checkbox"/> C	Nervousness	<input type="checkbox"/> P <input type="checkbox"/> C
Diarrhea	<input type="checkbox"/> P <input type="checkbox"/> C	Numbness/Tingling	<input type="checkbox"/> P <input type="checkbox"/> C
Digestive problems	<input type="checkbox"/> P <input type="checkbox"/> C	Osteoporosis	<input type="checkbox"/> P <input type="checkbox"/> C
Disc issues	<input type="checkbox"/> P <input type="checkbox"/> C	Stiffness (neck/back/limbs)	<input type="checkbox"/> P <input type="checkbox"/> C
Dizziness	<input type="checkbox"/> P <input type="checkbox"/> C	Sleeping issues	<input type="checkbox"/> P <input type="checkbox"/> C
Ear infections	<input type="checkbox"/> P <input type="checkbox"/> C	Urinary difficulty	<input type="checkbox"/> P <input type="checkbox"/> C
Headaches	<input type="checkbox"/> P <input type="checkbox"/> C	Vertigo	<input type="checkbox"/> P <input type="checkbox"/> C

Other: _____

NEUROLOGICAL STRESS TEST

Stress has been bombarding us from the time we were born to our present moment, and we will continue to experience stress as long as we are alive. Please circle when you have experienced these various stressors no matter how mild or severe your exposure may have been. Circle all that apply. **C** (child)

T (teenager) **A** (adult) **N** (none)

Worksheet below 

I. PHYSICAL STRESS	(CIRCLE)	Explanation, if needed:
Birth traumas (c-section, forceps, vacuum, etc.)	C T A N	
Slips/falls	C T A N	
Car accidents	C T A N	
Sports Injuries	C T A N	
Physical abuse	C T A N	
Work injuries	C T A N	
Poor posture	C T A N	
Sitting on wallet	C T A N	
Sleeping (position)	C T A N	
Extensive computer work	C T A N	
Carrying heavy purse/backpack/child	C T A N	
Repetitive lifting/bending	C T A N	
Driving for many hours	C T A N	
Continuous hours sitting/standing	C T A N	
Bone fracture/surgery	C T A N	

II. EMOTIONAL STRESS		
Relationships	C T A N	
Career	C T A N	
Children	C T A N	
Money	C T A N	
Fast-paced life	C T A N	
Hold in feelings	C T A N	
Quick tempered	C T A N	
Verbal abuse	C T A N	
Perfectionist	C T A N	
Procrastinator	C T A N	
Sickness	C T A N	
Loss of loved one	C T A N	

III. CHEMICAL STRESS		
Smoker or 2nd hand smoke	C T A N	
Poor diet	C T A N	
Caffeine (Amount?)	C T A N	
Excessive sugar	C T A N	
Artificial sweeteners	C T A N	
Vaccines	C T A N	
Prescription drugs	C T A N	
Over-the-counter drugs (Tylenol, Motrin, Allergy, etc)	C T A N	

IV. **Which do you feel is your primary category of stressor?** (circle) Physical / Emotional / Chemical

Please explain: _____

HIPAA: Consent for Use and Disclosure of Health Information

In compliance with federal law, a copy of the national standards for privacy of individually identifiable health information is available upon request. The privacy notice describes, in detail, how a member's health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of a member's health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example: by email or facsimile mail.

A copy of the privacy notice has been made available to me upon request.

Terms of Acceptance

As you begin this special type of care, it is essential for us to have a clear understanding in working towards the same important objective to meet your expectation and maximize your results

A chiropractic subluxation is a unique spinal condition that interferes with nervous system function, resulting in a lessening of your body's ability to express itself (function/work properly, heal itself, etc). A chiropractic subluxation is not a misalignment, a joint fixation, or medical condition.

A chiropractic adjustment is a specific force applied to the spine to reduce spinal subluxation, which increases nervous system function and therefore healing potential. A chiropractic adjustment is not a manipulation, a therapy, or a medical treatment.

Our objective is to minimize vertebral subluxations on a regular basis because the body adapts, heals, and performs better without them. There is very strong potential for conditions and symptoms to reduce with care. Regardless, the actual promise of chiropractic care is simply a higher level of healing, performance and body function, aside from other factors that may affect your health or symptoms.

Although many conditions improve with chiropractic care, it is not our objective to diagnose or treat any medical condition. Therefore, a medical provider should address any concerns you have beyond our specific objective. However, we will inform you if we become aware of a reason for you to seek additional care by another provider.

I accept the terms above and consent to care at Awaken Life Chiropractic on this basis.

Signature: _____ Date: _____

Consent to evaluate and provide care for a minor child:

As the parent or legal guardian of (print child's name): _____

I grant permission for my child to receive care at Awaken Life Chiropractic on the basis above

Signature: _____ Date: _____

Fees & Financial Policies



We accept: credit card, debit, check, cash, HSA / flex accounts

New Patient Assessment

\$135 for individual

+ **\$45** per additional family member

\$75 for referral (\$60 discount)

- Consultation and Health History
- Neuro-spinal exam
 - Computerized nerve scans measure hidden stress & dysfunction within your neuro-spinal system
- Customized report (upon follow-up visit)
- Doctor's recommendations (upon follow-up visit)

1

Corrective Care

\$360 / month — 3x per week

\$240 / month — 2x per week

+ **%20 off** per additional family member

* Your recommended care plan is determined by your exam results and personal health goals

2

Wellness Care

\$120 / month — 1x per week

+ **\$40** per additional family member

* Every other week plans available upon doctor/patient agreement

3

Progress Exams

\$45 ea.

- Neuro-spinal evaluations are designed to monitor progress and track changes. During your initial care plan we will perform progress exams every **12-18 visits**. Once you have graduated to Wellness Care, progress exams are performed less frequently.

I have read and I understand the fees and financial policies and I agree to follow them. Cancellation policy: If you decide to cancel your chiropractic care at any time, you must verbally, or in written form, notify the doctor(s) at Awaken Life Chiropractic and the office will be sure to cancel future payments.

Member's Signature _____ Date ____ / ____ / ____

Doctor's Signature _____ Date ____ / ____ / ____