

BODY OF LIGHT FAMILY CHIROPRACTIC

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ADULT

Welcome! We are honored that you have chosen both chiropractic and our office to help your body reach its optimum health potential. We invite you to breathe, relax and be open to the healing miracles that routinely happen with chiropractic care.

Today's Date: _____

GENERAL INFORMATION:

Full Name: _____ Sex: M F Age: _____ DOB: _____

Home#: (____) _____ Cell #: (____) _____ Work#: (____) _____

E-mail Address: _____ Soc. Sec.#: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Marital Status: S M D W Name of Spouse: _____

Employer: _____ Position/duties: _____

Have you ever received chiropractic care? Yes No With whom? _____

Date of last visit: ____/____/____ Reason for ending care? _____

Names and Ages of Children: _____

Have your children received chiropractic care? Yes No With whom? _____

Emergency Contact: _____ Phone #: (____) _____

Whom may we thank for referring you? _____

Our Chiropractic Principles/Foundation:

- The body is self-healing and self-regulating.
- The nervous system controls the body's ability to function and adapt (heal and regulate).
- Spinal misalignments (vertebral subluxations) cause interference to the nervous system.
- Chiropractors locate and correct vertebral subluxations with specific spinal adjustments.
- Adjustments remove pressure from the nervous system and allow the body to heal.

Health, Wellness and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These **stresses** may be **physical, chemical**, and/or **emotional** in nature. Understanding the physical, chemical, and/or emotional stresses that have acted upon your spine and nerve system assists us in serving you. We thank you in advance for answering the following questions as accurately and completely as possible.

History of Physical Stress: Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed.

Home Natural Hospital Drug induced Vacuum extraction
 C-section Breech Forceps Prolonged Umbilical cord around neck
Other complications: _____

Have you had any accidents related to the following: (Circle all that apply and give dates).

Automobile Motorcycle Bicycle Sports Falls Other: _____

If yes, please explain: _____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Yes No

If yes, please explain: _____

Have you broken any bones, had surgery, or been hospitalized? Yes No

If yes, please explain: _____

History of Chemical Stress: Chemical stresses occur during life due to any toxic substance that is breathed, injected, taken orally, or placed on the skin. The following will give us insight into any exposure you may have had.

Please list any medications you are currently on: _____

Do you consume: Alcohol Coffee/Caffeine Tobacco Other(s): _____

If yes, how much and for how long: _____

History of Emotional Stress: It is difficult to separate the emotional stress in our lives from the physical response that often occurs. Please indicate the stressors that you have experienced.

Childhood trauma Abuse Loss of loved one
 Illness Parental Divorce Relationships
 Family Work/School Lifestyle change
 Divorce/Separation Financial Other: _____

Please explain if necessary: _____

Health Conditions (present or past): (While these symptoms/conditions may seem unrelated to the purpose of the appointment, they may be related to the health/dis-ease of the nervous system).

headaches asthma allergies fainting diabetes
 neck pain pins&needles thyroid problems blood pressure kidney prob.
 stiff neck numbness diarrhea heart attack cancer
 mid-back pain tension constipation stroke **For Women:**
 low back pain fatigue psychiatric issues sinus problems pregnant
 dizziness loss of sleep ear infections arthritis birth control
 depression cold extremities cold sweats HIV/Aids pain menses
 nervousness restricted motion irritability ulcers/colitis irreg. cycles

Other: _____

Have you been under drug or medical care for any of these conditions? _____

Present State of Health (Presenting Symptoms). Finally, the years of continuing stress/damage may show up as acute or chronic symptoms. If you are seeking chiropractic care because of a specific complaint(s), please answer the questions below.

Present complaint: _____

How long have you been suffering with this problem? _____

Describe symptom (sharp/dull/numb etc.) _____

Is the symptom: getting better staying the same getting worse

Aggravated by? _____

Helped by? _____

Is the condition worse at a specific time of day? _____

How does the symptom(s) interfere with your life? (ie: sleep/work/play/lifting children etc.)

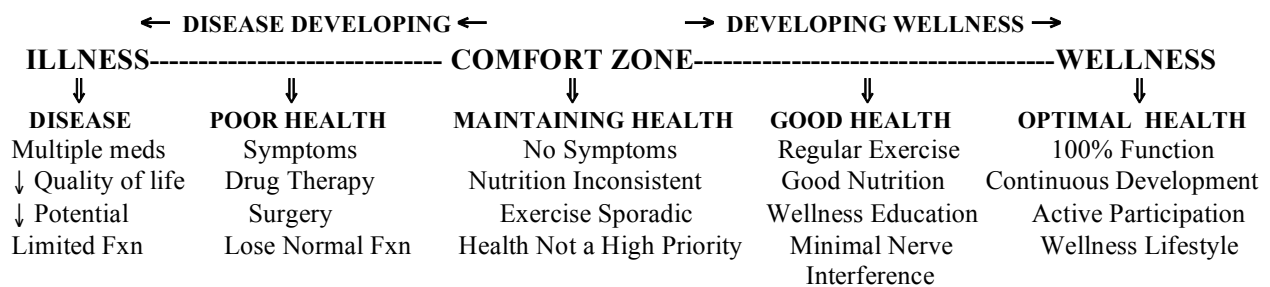
Have you seen other doctors for this condition(s)? _____

Results? _____

Quality of life and current health status:

How do you grade your physical health?	Excellent	Good	Fair	Poor
How do you grade your emotional/mental health?	Excellent	Good	Fair	Poor
How do you grade your overall "quality of life"?	Excellent	Good	Fair	Poor

Please look at the chart and indicate on the line below where you currently are on this health continuum. Mark your current status with an (A) and also use an arrow to indicate the direction your current health decisions are taking you. Then, indicate on the line where you would like your health to be in the future with the letter (B).



How long did it take you to get to your current health status (point A)? _____

How long do you think it will take to achieve your goal of future health (point B)? _____

What lifestyle choices brought you to point A? (lack of exercise, poor nutrition, injury etc.) _____

What lifestyle choices will help you achieve your health goals? (↑exercise, ↓junk food, etc): _____

How can we/chiropractic help you achieve your health goals? _____

Please check the choice(s) that most clearly describes your current goals for health and well-being: (check all that apply):

- I am concerned with my immediate problem (Relief Care).
- I am concerned with my immediate problem and preventing its return (Corrective Care).
- I want to achieve optimum function, health and well-being on every level that is available to me! (Wellness Care).

Financial Information: Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing.

Please indicate your method of payment: Cash Check Credit Card

If you have insurance, please indicate the type of policy and name of insurance carrier:

Health Insurance Auto (PIP) Medicare Flexible Spending Account/HSA

Name of Insurance Company: _____

ID# / Policy #: _____ Insurance Phone Number: _____

Name of Insured: _____ Date of Birth: _____

Authorization for exam (care) / Billing Insurance:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

Testimonials:

Many of our clients have had wonderful improvements in their health and well-being from chiropractic care. When this happens we often ask the client to write a testimonial about the results they have experienced so we may share their story with others who are unfamiliar with chiropractic. We often include a picture to go with their testimonial.

By signing below I give Body of Light Family Chiropractic permission to use my testimonial and/or picture of myself/family for the sole purpose of promoting chiropractic care.

I also acknowledge that I have read through and agree to the authorization for care and insurance policies described above.

Signature: _____ Date: ____/____/____

Thank you for choosing Body of Light Family Chiropractic. We are looking forward to helping you heal and express your full health potential!