BODY OF LIGHT FAMILY CHIROPRACTIC
396 E. 18th Ave. Eugene, OR 97401 (541) 687-7775
Melody J. Spear, D.C.
David H. Spear, Ph.D., D.C.

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.

GENERAL INFORMATION:

Full Name: _____ Sex:_____ Age: _____ DOB: _____

Cell/Home #: _____Work#: _____ E-mail: _____

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

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

Employer: _____

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

Names of Children: _____

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 interference to 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	__ menses pain
__ 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? _____
How much discomfort do you typically experience on a scale of 1 -10?_____

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)?_____

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 use the following states of health to answer to the next few questions:

A. DISEASE	B. POOR HEALTH	C. MAINTAINING HEALTH	D. GOOD HEALTH	E. OPTIMALHEALTH
Multiple meds	Symptoms	No Symptoms	Regular Exercise	100% Function
↓ Quality of life	Drug Therapy	Nutrition Inconsistent	Good Nutrition	Continuous Development
↓ Potential	Surgery	Exercise Sporadic	Wellness Education	Active Participation
Limited Fxn	Lose Normal Fxn	Health Not a High Priority	Minimal Nerve Interference	Wellness Lifestyle

How would you describe your current state of health using the above A-E choices? _____
Using the A-E options, what is your goal for your health status? _____

What lifestyle choices brought you to your current health status? (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 <u>all</u> 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.

Name of Insurance Company: _____

ID# / Policy #: _____

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.

I 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!