

Name _____ Male Female Date of Birth _____
 Home Phone _____ Cell Phone _____
 Address _____ City/State _____ Zip _____
 E-mail _____ SSN _____
 Do you prefer phone, e-mail, or text reminders? (please circle) If text, carrier name _____
 School _____ Grade Level _____
 Mother's Name _____ Father's Name _____
 Whom may we thank for referring you? _____
 Emergency Contact Person _____ Phone Number _____
 Have you had Chiropractic care before? No Yes- When/Where? _____
 Primary Care Physician: _____

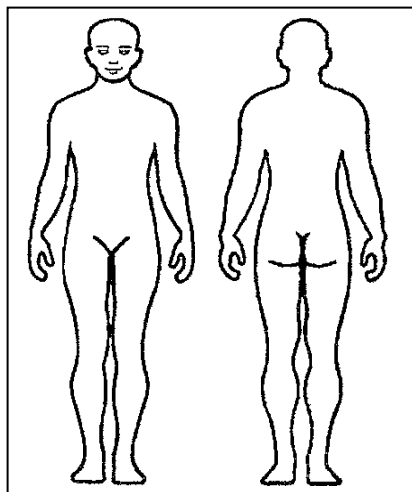
HOW CAN WE SERVE YOU? I have no complaints. I am here for a wellness check up. (please skip health concerns)

Is this condition due to a work or auto related accident? Yes No Date _____

Subluxations (spinal misalignments) cause most of the unwanted health conditions people suffer from every day.

Subluxations affect your nervous system, which affects your health.

Please mark an X on the picture where you are experiencing health concerns:



1. What is your *first* health concern? _____

First occurrence date: _____

Subluxations irritate nerve fibers causing various sensations. Which describes yours?

Sore Dull Aching Sharp Stabbing Burning Throbbing

Numbness Tingling Severity: please rate 1-10 (10 is worst) _____

Nerve pressure can be constant or occasional. How often is yours? (Circle one)

What makes it feel worse: Bending Laying Down Sitting Standing

What makes it feel better: Lying Down Sitting Standing Rest Movement

What treatment have you already received for your condition? ___ Medications

___ Surgery ___ None ___ Physical Therapy ___ Chiropractic ___ Other _____

2. What is your *second* health concern? _____

First occurrence date: _____

Subluxations irritate nerve fibers causing various sensations. Which describes yours?

Sore Dull Aching Sharp Stabbing Burning Throbbing Numbness Tingling

Nerve pressure can be constant or occasional. How often is yours? (Circle one) Severity: 1-10 (10 is worst) _____

What makes it feel worse: Bending Laying Down Sitting Standing

What makes it feel better: Lying Down Sitting Standing Rest Movement

What treatment have you already received for your condition? ___ Medications ___ Surgery ___ None ___ Physical

Therapy ___ Chiropractic ___ Other _____

Please check all that apply.

Neurological

- headaches
- numbness Where? _____
- tingling Where? _____
- nervousness
- tremors
- sciatica
- seizures
- depression
- fatigue
- sleeping problems
- unexplained weight loss
- loss of balance
- migraines
- fibromyalgia
- dizziness

Cardio-Vascular

- high blood pressure
- low blood pressure
- rapid heartbeat
- slow heartbeat
- heart attack
- chest pain
- stroke
- Eyes, Ears, Nose & Throat**
- frequent cold
- hearing loss
- failing vision
- ear infections
- ringing in the ears
- sinus infections
- thyroid trouble

Gastro Intestinal

- diarrhea
- constipation
- colon trouble
- bed wetting
- difficult digestion
- acid reflux
- nausea/vomiting
- colic
- Genito-Urinary**
- bed wetting
- frequent urination
- loss of urine control
- kidney infection
- prostate trouble

Respiratory

- asthma
- chronic cough
- sleep apnea
- difficulty breathing
- allergies

Do You Have

- autism
- diabetes
- cancer
- ADHD/ADD

For Females Only

- menstrual problems
- Pregnant, Due date? _____

Musculoskeletal

- neck pain
- upper back pain
- mid back pain
- low back pain
- Scoliosis

Joint Problems

- Knee R L
- Ankle R L
- Hip R L
- Shoulder R L
- Elbow R L
- Wrist R L
- Jaw R L

Patient Name _____ Today's Date _____

Please list medications you are currently taking and what you are taking them for.

1. _____ for _____ 2. _____ for _____ 3. _____ for _____

Complications during deliver? _____

Please list all surgeries _____

Please list all accidents _____

Is there anything else which may help us to better understand your history which has not been discussed on this survey? _____

Billing Information: Will your account be cash or insurance (please circle)?

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to Dr. Scoles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges if I do not have insurance.

Guardian Signature _____ **Date** _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third-party payers. 3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Guardian Signature _____ **Date** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or symptoms.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's healing wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Today's appointment will consist of the consultation, examination, and possible x-rays. The doctors will then review all findings and schedule a special appointment time in which they will explain in detail the results of your examination and go over your personal care plan. That appointment is called your Report of Findings. We prefer that you schedule this appointment within four days of today's appointment. There is no fee for your Report of Findings, however there is a fee for your first adjustment.

X-ray Consent:

The purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. I consent to chiropractic spinal x-rays.

Guardian Signature _____ **Date** _____

Consent to evaluate and adjust a minor:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Guardian Signature _____ **Date** _____