HOUSE OF HEALTH CHIROPRACTIC

Name_____ D.OB._____

Address_____ Zip_____

Phone_____ Email_____

Current employer/ job description_____

Marital status: single married divorced widowed separated, Number of children and ages_____

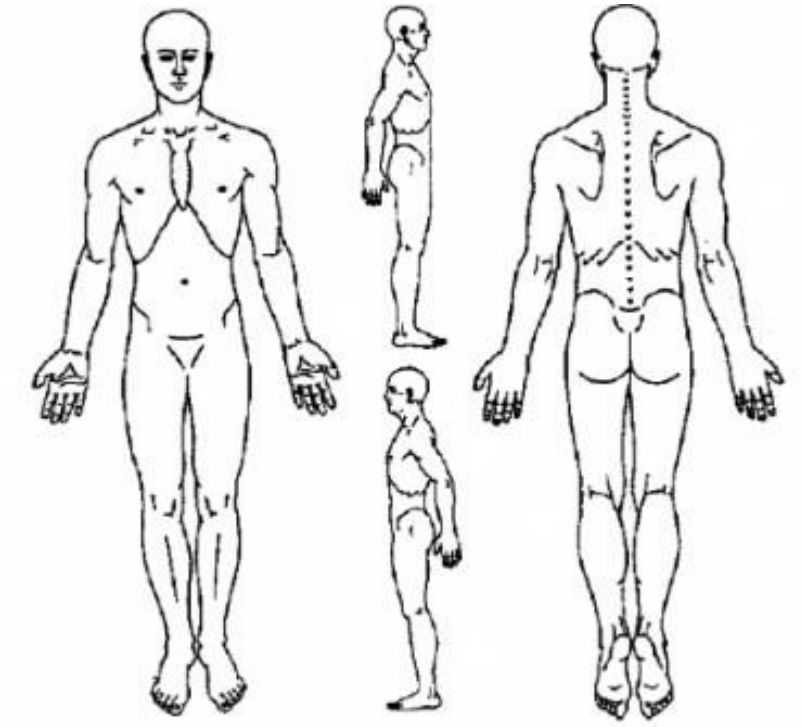
What brings you to our office?_____

What activities are you not able to participate in because of this problem?_____

What have you tried for this problem so far?_____

Do you have a family history of this or any type of health problems?_____

Please draw on the diagram where the problem is with the appropriate symbol.



Burning (BBB)
Aching (AAA)
Stabbing (SSS)
Tingling (TTT)
Numbness (NNN)
Sharp (PPP)
Stiffness (FFF)
Other (OOO)

Please describe when the problem is of the greatest burden and if is it getting better or worse. _____

Circle any of the issues you have had in the past or currently have.

| | | | |
|---|---|---|---|
| Skin Problems | Eye Problems | Ear, Nose Mouth, Sinus Problems | Respiratory problems |
| Cardiovascular Problems | Blood Problems | Immune Problems | Endocrine problems |
| Neurological Problems | Psychiatric Problems | Reproductive problems | Headaches |
| Neck Pain | Back Pain | Chest Pain | Dizziness |
| Depression/ Anxiety | Diarrhea | Constipation | Vomiting |
| Fatigue | Fainting | Cold Extremities | Numbness in Extremities |
| Shortness of Breath | Loss of Memory | Unexplained Fever | Loss of Smell |
| Loss of Taste | Loss of Balance | Sleeping Problems | Loss of strength in Extremities |
| Unexplained weight loss | Problems with bladder | Deep boring pain that wakes you up at night | |

Other:_____

Describe what your exercise regimen is like:_____

Describe your diet:_____

Do you drink alcohol, use any type of tobacco, or use any recreational drugs?_____

Please list all medications you are currently taking or took in the past, and why._____

Please list all injuries, hospitalizations, surgeries (Dates):_____

What is you daily stress level (**0**=none, **10**=most imaginable) **0 1 2 3 4 5 6 7 8 9 10**

Circle the number that describes your current state (**0**= worse possible **10**= best possible), and how you can improve.

Physical: **0 1 2 3 4 5 6 7 8 9 10**_____

Emotional: **0 1 2 3 4 5 6 7 8 9 10**_____

Spiritual: **0 1 2 3 4 5 6 7 8 9 10**_____

Intellectual: **0 1 2 3 4 5 6 7 8 9 10**_____

Financial: **0 1 2 3 4 5 6 7 8 9 10**_____

Occupational: **0 1 2 3 4 5 6 7 8 9 10**_____

How dedicated are you to working toward solving your health problems? **0 1 2 3 4 5 6 7 8 9 10**

Is solving your health problems someone else's responsibility? **Y / N**

Who is your medical doctor?_____

Have you ever been to a chiropractor before? **Y / N** Who?_____

Have you ever heard of vertebral subluxation? **Y / N**

Before accepting any new practice members it is important that we have a common understanding of the objective of House of Health Chiropractic and the role of the chiropractor and the role of the practice member. Your first visit will be a consultation, exam, and possibly an adjustment. Your second visit will include a report of findings and possibly an adjustment. The Report of Findings is where we will answer at least three specific questions for you: can we help you, how long will it take, and how much will it cost.

**Mission statement:** It is our mission at House of Health Chiropractic to improve the health and well being of our community through education in addition to adjusting vertebral subluxations, and our goal is to deliver this to every man, woman, and child for a reasonable fee on a referral basis for as long as clinically indicated and in the best interest of the practice member.

**Our services:** At House of Health Chiropractic we analyze and adjust vertebral subluxations when clinically indicated. It is our belief that connection between the brain and body is critical for proper function, and when this is disrupted (vertebral subluxation) the body cannot function or heal as it was naturally designed. We do not offer any medical diagnosis, nor treatment with drugs or surgery, but will refer to the appropriate avenue when clinically indicated.

**What we expect:** We expect that you will follow through with the care plan designed for you by our chiropractors based on your case. We expect that you will pay your bill in full. We expect that if we do a good job you will tell others, and if we do not you will tell us so we can grow together to better serve our community. We expect that if you are still reading you will circle the word *yes*.

**Informed consent:** It is likely that whatever brings you into our office will show improvement after clearing interference from the nervous system by adjusting vertebral subluxations. It is possible that the problem will not improve or possibly even get worse despite our best efforts. There is minimal danger associated with adjusting the spine. In some cases a sprain or strain can result, and if you have advanced osteoporosis there is the possibility of a rib fracture, and there is also the possibility that after your first adjustment the area adjusted might feel a little sore like if you worked out really hard for the first time. There are other treatment options besides safe, non-invasive, and inexpensive chiropractic care: drugs and surgery, and if that is your interest we will discuss that with you.

**Our fees:** Our fees are set to be fair and affordable in accordance with the service we offer, what we require of you, and the surrounding market. The first office visit will be at least an exam to determine the severity of your condition and if you are a good candidate for our office, and the fee is **$150.00**. For the initial intensive phase of care each adjustment is **$75.00**. We do offer pre-pay discounts which we are happy to discuss with you in person. If you wish to receive a super-bill to submit to your insurance company please inform us at the outset of care. There is a **$35.00** late cancellation fee if an appointment is cancelled less than 24 hours in advance.

I affirm that the information I have entered above is correct, and I have read and understand all the above statements and have the desire to be a practice member at House of Health Chiropractic.

Name_____Signature_____Date_____

HOUSE OF HEALTH CHIROPRACTIC

Date

Posture

ROM C

L

Muscle test C5 C6 C7 L4 L5 S1

C Compression

C Distraction

Shoulder Depressor

SLR

Kemps

Pelvic Rock

Valsalva

DX:

Adjustment:

Post:

Plan: