Holistic Life Chiropractic
2275 Deming Way, Middleton, WI 53562
www.holisticlifechiro.com

Please fill out the following information to the best of your knowledge, as completely as possible.

***GENERAL INFORMATION**

Today's Date: ____/____/_____ **Title**: Mr. / Mrs. / Ms. / Dr. / Prof. **Sex**: Male / Female / Unspecified

First Name: _____ **Middle Name**: _____ **Last Name**: _____

Nickname: _____ **Date of Birth**: _____/_____/_____ **Age**_____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: _____**Secondary Phone**: _____

E-Mail Address: _____ **Referred By**: _____

Emergency Contact Name: _____ **Phone #:** _____

Children Ages:_____ **Marital Status**: Single / Married / Other

Employment Status: Employed / Full-Time Student / Part-Time Student / Other / Retired /Self-Employed

Type of Work Performed/Employer: _____

Though we are a cash-based practice and payment is due at the time of service, we are able to print off SuperBills for your reimbursement if our services are covered by your health care insurance provider. **Insurance Company**: _____

Race: (circle one)

White	Black/African American	Hispanic	American Indian/Alaskan Native
Asian	Asian Indian	Chinese	Filipino
Japanese	Korean	Vietnamese	Native Hawaiian/Pacific Island
Samoan	Guamanian or Chamorro	Other	I choose not to specify.

Multi-Racial: Yes / No / Unknown

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Choose not to specify.

Preferred Language: (circle one)

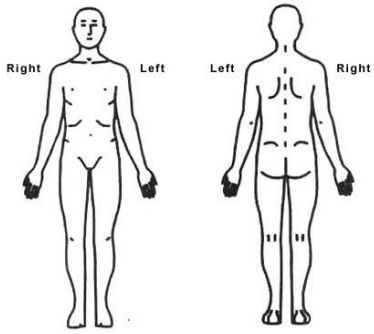
English	Spanish	Armenian	Chinese	French	German
Tagalog	Vietnamese	Italian	Korean	Russian	Polish
Arabic	Portuguese	Japanese	Hindi	Greek	French Creole
Persian	Urdu	Gujarati	American Sign Language		I choose not to specify

Verification Question: (choose one question by circling it, then give the answer to the question – *must be 6 letters or longer*)

What is the name of your favorite pet?
What high school did you attend?
What is your mother's maiden name?
What was the make of your first car?
In what city were you born?
What is your favorite movie?
On what street did you grow up?
When is your anniversary?

Answer to the verification question chosen above: _____

Reason for Today's Visit: _____



(Please use the diagram to mark areas that are bothering you.)

Severity: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Have You Experienced This Previously? Yes / No

Symptoms Began: **Date** ____/____/_____ **Or Age:** _____

Is it: Job-Related / Auto Accident / Injury / Fall / Other

Have you seen anyone else for this? _____

How does this affect your daily life? _____

What are your goals/expectations from care: _____

Have you ever seen a Chiropractor / Massage Therapist / Naturopathic Doctor / Acupuncturist **?**

Other health concerns you would like to discuss: _____

CURRENT HISTORY

***Current Medications** (including start date, frequency and dosage if known)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Current Supplements: _____

***Allergies/Sensitivities (including Medications)**: _____

***Known Health Problems**: _____

Family History of Health Problems: _____

Have you broken any bones? Yes / No **If yes, which one(s) and when**? _____

***Have you had any x-rays or MRIs of your spine taken in the last year**? Yes / No _____

Have you ever had any accidents, falls, traumas or motor vehicle accidents? Yes / No If yes, please explain: _____

Have you ever been admitted to the emergency room or hospital? Yes / No _____

Have you ever had surgery? Yes / No **If yes, describe and give the date**: _____

Date of Last Physical : ___/____/_____ **Females Only – Date of Last Period**: ___/____/_____

LIFESTYLE AND HABITS

Do you use any of the following: Alcohol / Recreational Drugs / Pain Relievers / Artificial Sweeteners

Do you drink coffee, soda, or caffeinated beverages? Yes / No If yes, how many per day? _____

***Do you smoke or use tobacco**? Current Smoker / Former Smoker / Never Been a Smoker _____

How many hours of sleep do you get each night? _____ **Is it restful sleep**? Yes / No

Do you exercise regularly? Yes / No **If yes, what activities and how often**?_____

How many ounces of water do you drink each day? _____

How would you rank your dietary choices and habits on a scale of 1-10, 10 being the best? _____

Please circle the symptoms you are currently experiencing or have had serious issues with in the past:

GENERAL:

Changes in Appetite	Poor Appetite	Cravings	Strong Thirst
Thyroid Issues	Weight Loss	Weight Gain	Easy to Bleed or Bruise
Poor Balance	Fevers/Chills	Heavy Sweating	Shaking/Tremors/Tics
Sudden Energy Drops	Poor Sleep/Fatigue	Never Sweating	Night Sweats
*Diabetes (Type:___, HgA1C:_____)	Puffiness or Swelling	Weakness	Lumps or Tumors

MUSCULOSKELETAL:

Muscle Spasms/Cramping	Muscle Weakness	Muscle Achiness	Numbness or Tingling
Intervertebral Disc Issues	Arthritis	Osteoporosis	Scoliosis
Low Back Pain	Middle Back Pain	Neck Pain	Hip/Leg/Knee Pain
Shoulder/Arm Pain	Ankle/Foot Pain	Hand/Wrist Pain	Facial Pain
Sensitivity to Touch/Pressure	Pain with Activity	Weak/Stiff Joints	Pain with Weather Changes

CARDIAC & CIRCULATION:

*High Blood Pressure	Low Blood Pressure	Anemia	Clotting Disorder/Blood Clots
Cold Hands or Feet	Swelling of Hands	Swelling of Feet	Fainting
Phlebitis	Irregular Heartbeat	Palpitations	Lightheadedness
Chest Pain	Heart Attack(s)	Stroke(s)	Coronary Artery Disease

HEAD, EENT:

Dizziness	Blurry Vision	Spots in Vision/Floaters	Cataracts
Eye Strain/Pain	Night Blindness	Vision Changes	Glasses/Contact Lenses
Problems with Smell	Nose Bleeds	Sinus Problems	Lip or Tongue Sores
Recurrent Sore/Scratchy Throat	Problems with Taste	Toothache	Voice Changes
TMJ/Jaw Pain	Headaches	Migraines	Concussions
Poor Hearing	Ear Aches	Hearing Loss	Ear Ringing

SKIN & HAIR:

New or Abnormal Moles	Rashes/Hives	Skin Ulcers	Itching/Dryness
Eczema/Psoriasis	Pimples/Acne	Dandruff	Hair Loss/Thinning

NEUROPSYCHOLOGICAL:

Trouble Concentrating	Seizures/Epilepsy	Lack of Coordination	Poor Memory
Irritability/Mood Swings	Anxiety/Depression	Stress	Personality Changes

RESPIRATORY:

Cough	Pneumonia	Asthma	Bronchitis
Coughing Up Blood	Painful Breathing	Difficulty Breathing	Easily Winded

GASTROINTESTINAL:

Indigestion/Hearturn	Nausea	Vomiting	Belching
Bad Breath	Intestinal Gas	Bloating	Abdominal Pain/Cramping
Diarrhea	Constipation	Chronic Laxative Use	Hemorrhoids
Blood in Stools	Ulcers	Rectal Pain	Gallbladder Stones

UROLOGY:

Unable to Hold Urine/Incontinence	Painful Urination	Cloudy Urine	Blood in Urine
Decrease in Urine Flow	Frequent Urination	Urgency to Urinate	Frequent Night Urination
Pain in Groin Area	Kidney Stones	Sexually Transmitted Diseases	

(FEMALES ONLY)

Age of Menses: _____ years old Duration of Menses:____days # of Pregnancies: _____ # of Births: _____

Irregular Periods	Painful Periods	Spotting	Clots
Vaginal Discharge Changes	Yeast Infections/Vaginosis	Breast Lumps	Tender Breasts
PMS Symptoms	Fertility Problems	Menopausal – Peri/Post	Age of Menopause:_____ years

***CLINIC USE ONLY**:

HEIGHT: _____ inches **WEIGHT**: _____lbs **BLOOD PRESSURE**: _____/_____mmHg

Holistic Life Chiropractic

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

(print name) (signature) (date)

Consent to evaluate and adjust a minor child:

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

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

_____ _____

(signature) (date)

Holistic Life Chiropractic

Office Policies

Thank you for selecting Holistic Life Chiropractic to provide chiropractic care for you and your family. Please note the following office policies:

Holistic Life Chiropractic is a cash based office; this means that payment is expected from our patients for all services performed. We do offer several different payment options for the program of care you are about to receive in our office. As an alternative to collecting fees at each visit, we have developed these options to streamline your payments and to remove any financial obstacles. Our intent is to make it both convenient and less costly for you to receive the care that you need.

_____ 1. Patients pay in full at each office visit for the services rendered that visit.
_____ 2. Nuclear families that come in for care together can participate in the following plan: the first family member is regular price, the second receives a $10 discount, the third family member receives a $20 discount and all additional family receive a $30 discount.

Patient Agreement:
By signing this form, I understand that:

1. Payment is required at the time of service, or at the time of purchase of any supports, supplements, or supplies.
2. I am to make uninterrupted payments based on the plan I have selected until my account balance reaches zero.
3. That no further care shall be rendered should any payment become seven days past due (unless other arrangements are made).
4. That if I discontinue care for any reason (other than discharge by the doctor) all outstanding balances shall immediately become due and payable.
5. After my initial visit, I will be given a plan for care. I understand that I need to follow that plan to obtain the results we both desire. If I need to change an appointment, I will try to keep as close to the original plan as possible so that the continuity of my care will not be interrupted.
6. 24 hours notice is expected if I cannot keep an appointment. Holistic Life Chiropractic may charge me a $25 missed appointment fee for any appointments for which I do not call or show.

The above policies, options, and all costs associated with my care in this office have been thoroughly explained to me. I wish to participate in this plan of payment for the professional services that I will receive.

_____ _____
Signature of Patient or Guardian Date