

Today's Date: ___/___/___ Date of Birth: ___/___/___ e-mail address: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ___ Zip: _____

Male ___ Female ___ Single ___ Married ___ Divorced ___ Widowed ___ Domestic Partner ___

(Please circle the best phone number to contact you)

Home Phone: ()-___-___ Work Phone: ()-___-___ Cell Phone: ()-___-___

Occupation: _____ Employer Name & Address: _____

Spouse's Complete Name: _____ Spouse's Date of Birth: ___/___/___

Spouse's Occupation: _____ Number of Children: _____ Children living at home? Y or N

Name & Ages of Children at Home: _____

Whom may we thank for referring you to our office? _____

***Please List your reason(s) for seeking services at The Zone Healing Center:**

Please check any symptoms or conditions that you have ever experienced, even if you don't think they are related to your reason for seeking care.

***Please circle anything that you are currently experiencing:**

- | | | | | |
|---------------------------------------|---|--|--|--|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Spinal Surgery |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Back Pain | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Sensitive Eyes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Other (describe): |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Ringing in Ears | |

Please list any medications you are currently taking and what conditions you are taking them for, even if you don't think they are related to your reason for seeking care:

Please list any and all diagnoses that you have been given, even if you don't think they are related to your reason for seeking care.

Please briefly describe your understanding of your Nervous System and its function.

Rank your **Stress Level** at work. (LOW 1 2 3 4 5 6 7 8 9 10 HIGH)

Family/Relationship **Stress Level** (LOW 1 2 3 4 5 6 7 8 9 10 HIGH) Why?

What is your level of commitment to yourself, your life and well-being? **HIGH - MEDIUM - LOW**

As a result of my care in this office, I would like to (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Feel better quickly. | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy. |
| <input type="checkbox"/> Live a healthier lifestyle. | <input type="checkbox"/> Experience TRUE Health. |

HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Before we can begin any health care for you we require you to read and sign this consent form stating that you understand these policies and practices. If you do not sign this consent form, we reserve the right to refuse to provide you care in our office.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Your signature below indicates that you understand and agree to allow this chiropractic office to use your health information for the purposes of chiropractic care, payment, practice operations, and coordination of care. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for care. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

Your consent on this form need only be obtained one time for all subsequent care provided to you by this office. You may provide a written request to revoke your consent at any time during your care. This would not affect the use of those records for any care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. You further agree that we may contact you for appointment reminders and follow-up, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I have read and understand how my health information will be used by this office and I agree to these policies and procedures.

(PRINT NAME)

(SIGNATURE)

_____/_____/_____
Date

TERMS OF ACCEPTANCE

When one seeks chiropractic health care is accepted for such care, it is essential for both doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it.

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

Health: A state of optimal physical, mental, and spiritual well being, not merely the absence of disease or infirmity.

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 innate ability to express its maximum health potential.

Chiropractors do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, non –chiropractic or unusual findings are encountered, you will be advised.

Regardless of what the disease is called, chiropractors do not offer to treat it. Nor do chiropractors offer advice regarding treatment prescribed by others. The chiropractor's only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. The only method is specific adjusting to correct vertebral subluxations.

I, (print name) _____ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____
(Signature of parent or guardian if patient under 18 years old)

Date: ____/____/____