

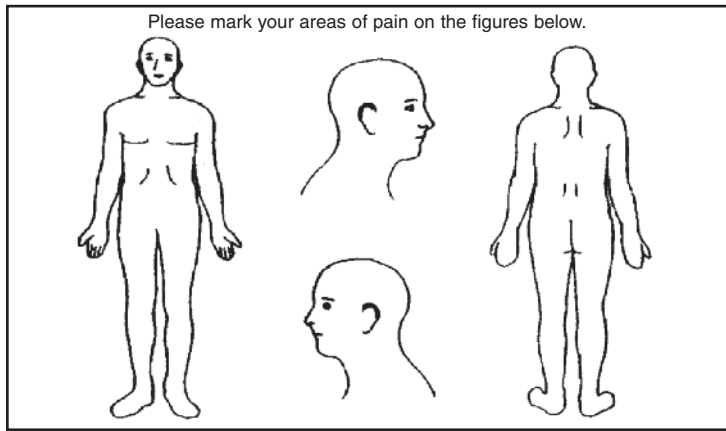
SHARE ZONE HEALING WITH YOUR FRIENDS AND FAMILY

LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 SINGLE MARRIED OTHER _____ # OF CHILDREN _____
 OCCUPATION _____
 EMPLOYER _____
 PHONE (hm) () _____ (wk) () _____
 E-MAIL _____
 REFERRED BY _____

FIRST NAME _____ MIDDLE _____ Male Female
 SS# _____ BIRTHDATE _____ AGE _____
 DRIVER'S LICENSE# _____ HEIGHT _____ WEIGHT _____
 SPOUSE'S NAME _____
 SPOUSE'S OCCUPATION _____
 EMPLOYER _____
 Contact in case of emergency _____
 Phone (hm) () _____ (wk) () _____
 DO YOU HAVE HEALTH INSURANCE? YES NO

What is your major complaint? _____

 Other complaints? _____
 How long have you had this condition? _____ Have you had this or a similar condition in the past? _____
 Did your condition occur while at work? Yes No When? _____
 Is this condition the result of a car accident? Yes No When? _____
 Is this condition getting progressively worse? Yes No Constant Comes and Goes _____



- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Numbness-Arms | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness-Legs | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Pain/Noises | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Restricts Regular Exercise | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Pressure High/Low | <input type="checkbox"/> Tiredness/Fatigue |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ |

This is a new/old illness. It was/was not treated before.
 If treated before, what was done? _____
 Name of Doctors: _____
 Have you ever had surgery or been hospitalized? Yes No
 List Surgeries: _____
 Have you ever had Chiropractic care before? Yes No
 Name of Doctor _____ Date _____
 Last time you had spinal X-rays or other X-rays: _____
 Medications you now take: _____

From birth to present please list by date/describe.
 1) Car Accidents _____

 2) Falls/Injuries (including Sports) _____

 3) Other _____

(FOR DOCTORS USE ONLY)

Insurance Co. _____
 Secondary _____
 Ded. _____ M _____ NM _____
 Benefits % _____ x-r % _____
 # Visits/CY _____
 DME: _____
 Special provisions _____
 C.P. W _____
 M _____
 P.V. _____
 Health Study scheduled: _____
 Health Study attended: _____

PATIENT'S SCHEDULE	
1	
2	
3	
4	
5	
6	
CASES REFERRED BY THIS PATIENT (Names and Dates)	
1	
2	
3	
4	
5	
6	

PATIENT REPORTING	0 - NO SYMPTOMS	9 - 10% IMPROVEMENT
	1 - 90% IMPROVEMENT	10 - NO IMPROVEMENT - START
	2 - 80% IMPROVEMENT	11 - 10% WORSE
	3 - 70% IMPROVEMENT	12 - 25% WORSE
	4 - 60% IMPROVEMENT	13 - 50% WORSE
	5 - 50% IMPROVEMENT	14 - 75% WORSE
	6 - 40% IMPROVEMENT	15 - 100% WORSE
	7 - 30% IMPROVEMENT	16 - NEW CONDITION
	8 - 20% IMPROVEMENT	17 - REAGGRAVATED OLD CONDITION

D.I. _____ D.O. _____			
E1	E2	E3	E4
C1	C13	T9	L6
C2	C14	T10	L7
C3	C15	T11	L8
C4	C19	T12	L9
C5	T1	T13	L10
C6	T2	T14	L11
C7	T3	L15	L12
C8	T4	L1	L13
C9	T5	L2	L14
C10	T6	L3	L15
C11	T7	L4	
C12	T8	L5	SD

ADDITIONAL

Laws of Life _____
 Inner Klean Diet _____
 Patient Testimonial _____
 Handouts: _____
 Exercises: _____
 Other: _____

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 towards the same objective.

Chiropractic has only one goal. It is important that each patient 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. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social 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.

We 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, 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 a health care provider who specializes in that area.

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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
print name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

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 terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date