INSPIRED LIVING CHIROPRACTIC
A Family Wellness Center
Adult

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER ADDRESS:	
WORK PHONE:	POSITION TITLE:

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ❑ YES ❑ NO

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO

DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES ❑ NO

DO YOU EXERCISE REGULARLY? ❑ YES ❑ NO

DO YOU WEAR:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ INSULIN
❑ STIMULANTS	❑ PAIN KILLERS
❑ TRANQUILIZERS	❑ BLOOD PRESSURE MEDICINE
❑ MUSCLE RELAXERS	❑ OTHER

MEDICATION & DOSAGE	REASON FOR TAKING

ALLERGIES:_____

_____

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. I F YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE:
❑ WELLNESS ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ JOB ❑ CHRONIC DISCOMFORT ❑ OTHER
PLEASE EXPLAIN:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONCERN INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

SUPPLEMENTS YOU TAKE

❑ ESSENTIAL FATTY ACIDS	❑ PROBIOTIC
❑ MULTIVITAMIN WHICH :_____	❑ OTHER_____
❑ CALCIUM / MAGNESIUM	❑ OTHER _____
❑ VITAMIN C	❑ OTHER _____

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960 6th St. Suite 2
Jesup, IA 50648

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❑ YES ❑ NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

"The doors we open and close each day decide the lives we live."

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Which best describes your reason for consulting our office?

❑ I have a specific concern and require help with this concern.

❑ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

❑ I want to be healthier five years from now than I am today.

YOUR FUTURE HEALTH

ARE YOU HEALTHIER THAN YOU WERE 5 YEARS AGO? ❑ YES ❑ NO ❑ NOT SURE
IF SO, WHAT DID YOU DO TO IMPROVE YOUR HEALTH?
IF NOT, WHY DO YOU THINK YOUR HEALTH DECLINED?
WILL YOU BE HEALTHIER 5 YEARS FROM NOW THAN YOU ARE TODAY? ❑ YES ❑ NO ❑ NOT SURE
IF SO, WHAT ARE YOU PLANNING TO DO TO IMPROVE YOUR HEALTH AND IF NOT, WHAT COULD YOU DO TO IMPROVE YOUR HEALTH RATHER THAN HAVE IT CONTINUE TO DECLINE?
AFTER MAIKING THESE CHANGES IN YOUR LIFE, WHO DO YOU EXPECT YOUR HEALTH TO BE 5 YEARS FROM NOW?

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

OTHER:

_____

_____

_____

HEALTH CONDITIONS...

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/LEGS/ HANDS	❑ NUMBNESS	**FOR WOMEN ONLY:**
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ LOW BLOOD PRESSURE	❑ ALLERGIES	DATE OF PREGNANCY _____ OUTCOME _____
❑ LOWER BACK PROBLEMS	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES	_____ _____
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ SURGERIES:	_____ _____
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	WHEN WAS YOUR LAST PERIOD? _____
❑ CONGENITAL HEART DEFECT	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	ARE YOU PREGNANT? ❑ YES ❑ NO ❑ NOT SURE
❑ FREQUENT NECK PAIN	❑ CHEMOTHERAPY	❑ SHINGLES	❑ DIZZINESS	

MEDICAL HISTORY

Please list the cause of death and age of any immediate family members (parents or siblings)

RELATIONSHIP	CAUSE OF DEATH	AGE OF DEATH

SURGERIES		
DATE	TYPE	REASON FOR SURGERY

PREVIOUS INJURIES OR TRAUMA (PLEASE GIVE TYPE AND DATE):_____

_____

_____

E-PRACTICE FORM

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring at Inspired Living Chiropractic: A Family Wellness Center (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our traditions of exceeding all your expectations.

NAME:	EMAIL ADDRESS:

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with Inspired Living Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ *Date:*_____

*Patient or Guardian Signature:*_____ *Date:*_____

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AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

SIGN IF READ ABOVE _____ DATE_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. 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. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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