NEW MEMBER PAPERWORK

WWW.LEVA.US

Name: _____ Date: _____

E-mail Address: _____ Gender: M F

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Physical Address: _____ Mailing: _____

City/State/Zip: _____ Marital Status: S M W D

Age: _____ Birthday: _____ # Of Children: _____

Name Of Your Employer: _____ Occupation: _____

Name Of Significant Other: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship To Member: _____

MEDICAL HISTORY

Main Symptoms & Severity(0-10 Scale)	Date Symptom Started	Duration of Symptom
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

How are these symptoms affecting the things most important in your life?

1. _____

2. _____

3. _____

Were you injured on the job / auto accident? Yes No

Have you missed any days from work or school? Dates: _____

What, if anything makes it feel better? _____ Worse? _____

What other doctors did you consult for this condition? (Names & Dates): _____

Their Diagnosis: _____ Results: _____

Please list any past accidents or falls: _____

Please list any broken bones/fractures: _____

Have you had any surgeries/hospitalizations? _____

Date of Last Physical Exam: _____ Date of Last Chiropractic Exam: _____

Height: _____ Weight: _____

Female's only

Are you pregnant? Yes No Please Initial Here: _____

Date of last menses: _____

Dr. Ryan Saint

LEVA chiropractic

Who can we thank for referring you? _____

PLEASE FILL OUT ALL AREAS

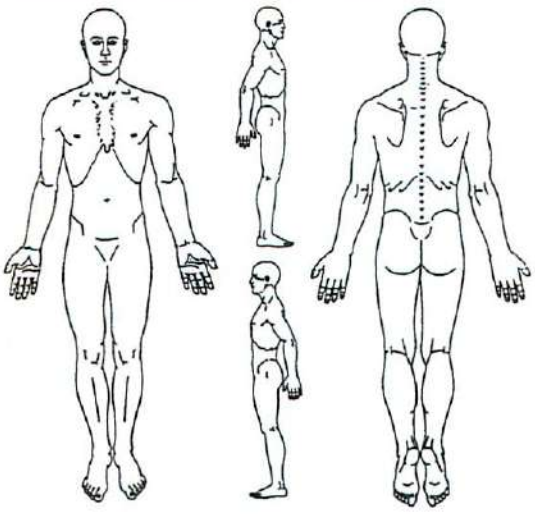
List any imaging of your spine (X-Rays/MRI/CT Scans) _____

Where you received these images: _____

***PLEASE BRING THESE WITH YOU TO YOUR NEXT APPOINTMENT SO WE CAN BETTER TO ASSIST YOU.**

Please check the conditions that you or anyone in your family <u>currently</u> has, or have had in the <u>past</u>:

SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2	SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2	SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2
NECK PAIN					VISION/EYE TROUBLE					COLD HANDS				
HEADACHE					NERVOUSNESS/ANXIETY					COLD SWEATS				
ARM PAIN					DEPRESSION					ARTHRITIS				
ARM NUMBNESS					NOSE BLEEDS					ANEMIA				
GOUT					SINUS TROUBLE					HOT FLASHES				
CHEST PAIN					DIFFICULTY SWALLOWING					MENSTRUAL PAIN / IRREGULARITY				
LOW BACKACHES					DIABETES					SLEEP WALK OR TALK				
MID BACKACHES					BITE TONGUE/CHEEK					THYROID ISSUES (HYPER/HYPO)				
LEG PAIN					ALLERGIES					PAIN BETWEEN SHOULDERS				
LEG NUMBNESS / TINGLING					ASTHMA					HEART TROUBLE				
SCIATICA					ADHD					LOW BLOOD PRESSURE				
JOINT SWELLING					BED WETTING					HIGH BLOOD PRESSURE				
LOSS OF APPETITE					FAINTING					LUMPS IN BREAST / CHEST				
LOSS OF SMELL					FEVER					CANCER				
LOSS OF TASTE					FOOD ALLERGIES					HAND NUMBNESS / TINGLING				
DIZZINESS					ULCERS					FIBROMYALGIA				
NAUSEA					COLITIS					MULTIPLE SCLEROSIS				
BUZZING/RINGING IN EARS					DIARRHEA					TREMORS				
PLUGGED EARS					POLIO					IRRITABLE BOWEL SYNDROME				
LIGHT SENSITIVITY					BRAIN FOG					CEREBRAL PALSY				
IRRITABILITY					CONSTIPATION					SLEEPING PROBLEMS / RESTLESS				
CLUMSINESS					HEMORRHOIDS					NIGHTMARES / NIGHT TERRORS				
FATIGUE / TIRED					FREQUENT URINATION					SKIN CONDITIONS				



<u>PAIN CHART:</u>

-Please write the **<u>number(s)</u>** on the body drawing that most closely describes the sensations you feel.

-Use **<u>arrows</u>** to show radiating pain or odd sensations.

Fill this out very accurately.

1 = Numbness
2 = Tingling
3 = Burning
4 = Ache
5 = Sharp
6 = Throbbing
7 = Stabbing
8 = Pins & Needles

SIGNATURE: _____

DATE: _____

TERMS OF ACCEPTANCE

Chiropractic has only one goal. It is important that each member understand both the objective & the method that will be able to attain it. This will prevent any confusion or disappointment.

Health: *a state of optimal physical, mental, & social well-being, not merely the absence of disease.*

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.*

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.*

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 evaluation, 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: _____

PURPOSE STATEMENT

At this very moment families in our community are sick, suffering, stressed, & overmedicated. Our purpose is to improve their lives for generations. We exist to educate all individuals on the power of the body's innate ability to express optimal life when stress is removed from the nervous system.

COMMITMENT TO OUR MEMBERS

We are committed to the transformation of your life through removing stress off your nervous system & passionately providing a rhythm of specific adjustments, lifestyle support, & advanced training so you may live life to its fullest potential.

OPEN CONCEPT PRIVACY

The adjusting area of our office is an open concept. However, we understand that you may, at any time, desire to have a private room where you can have a conversation with Dr. Sweet or to receive your adjustment. Should such a desire arise we are happy to accommodate that request. Please let any of our staff know & we will move you into a private room. If you are more comfortable with adjustments in a private room, you may also request to have a room scheduled for your visits. Please communicate your requests with our staff & we will make sure to arrange that.

SIGNATURE: _____ DATE: _____

FINANCIAL RESPONSIBILITY/OBLIGATION

** PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Our office is a vertebral subluxation and wellness-based office, we do not treat symptoms nor do we diagnose disease. We do not accept 3rd party contracts. It is expected that insurance will not cover any of our services. We will match Medicare fees; however Medicare will not cover the adjustments for symptom care nor wellness care.

For any service that you receive in our office, it is your responsibility to cover the cost. You may do so in the following ways: cash, check, credit, or debit.

I HAVE READ AND UNDERSTAND THE POLICY REGARDING FINANCIAL OBLIGATION.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

HIPAA FORM

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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to that extent that you have taken action relying on this consent.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

AUTHORIZATION TO TREAT A MINOR

We must have permission from a parent/legal guardian of a minor before providing chiropractic treatment or evaluation. Please fill out the following information for us to include in your child's medical records.

CHILDS NAME: _____
(PRINT NAME)

I am the parent/legal guardian of the person listed above and I authorize Leva Chiropractic (Dr. Ryan Sweet) to provide chiropractic care as needed.

PARENTLEGAL GUARDIAN'S NAME: _____
(PRINT NAME)

SIGNATURE: _____ DATE: _____

LIFESTYLE

It has been shown that **daily lifestyle stress significantly impacts your overall health & well-being.** As a family wellness office, we specialize in not only removing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health & wellness.

Please Rate the Following & Check All Answers That Apply to Your Habits:

Eating Habits:
- ☐ I eat 3-5 times a day
- ☐ I eat fruits & vegetables daily
- ☐ I eat out 2-3 times a week (min)
- ☐ I crave sweets
- ☐ I don't watch what I eat

Exercise Habits:
- ☐ I exercise 3-5 times a week
- ☐ I walk daily
- ☐ I don't exercise
- ☐ I want to exercise
- ☐ I sit for 5+ hours a day

Sleep:
- ☐ I sleep 7-9 hours a night
- ☐ I wake up well rested
- ☐ I wake up tired
- ☐ I toss & turn
- ☐ I stay up late

Mind Set:
- ☐ I have a positive outlook
- ☐ I have a negative outlook
- ☐ I am always in a good mood
- ☐ I am always in a bad mood
- ☐ I trap things inside
- ☐ I share easily

General Health:
- ☐ I am not on medications
- ☐ I take care of myself
- ☐ I base my health on how everyone around me is doing
- ☐ I think I am healthy but know I could make some changes

On A Scale Of 1-10 Describe Your Psychological/Emotional Stress Levels: (0 = None / 10 = Extreme)

Occupational: _____

Personal: _____

Overall Health: _____

Check The Following That Apply: ☐ Tobacco ☐ Alcohol ☐ Coffee ☐ Drugs ☐ Overeating ☐ Soda

List Any Vitamins/ Supplements You Are Currently Taking: _____

What Medications Are You Taking? (If Any) _____

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possible, it is important that we understand your goals for your overall health & well-being.

Please list your goals for your health & wellness in the spaces provided:

PHYSICAL GOALS	NUTRITIONAL GOALS	PSYCHOLOGICAL GOALS

COMMENTS: _____

_____

https://www.facebook.com/levachiropractic