

Life Story

Vital Information

Name _____ Date ____/____/____

I prefer to be called _____

Address _____

City _____ State _____ Zip _____

Home # _____ - _____ - _____ Work # _____ - _____ - _____ Cell # _____ - _____ - _____

Preferred Contact # h | w | c _____ Email _____

Birthday ____/____/____ Age _____ SSN _____ - _____ - _____

Occupation _____ Employer _____

Marital Status Married Single Widowed

Spouse/Partner Name _____

Do you have children? y | n How many? _____

Names & Ages of all Children _____

Reason for seeking our services? _____

What other action steps have you taken? _____

Who can we thank for referring you to Healing Touch Chiropractic?

Have you ever been adjusted by a Chiropractor? y | n

Who & Where? _____ Date of last adjustment? ____/____/____

Do you have a Primary Care Provider? y | n

Who & Where? _____

Is there anything about your Nerve System and Spine we should know about?

Additional comment (s) _____

Other Avenues of Healing

Have you ever used or do you use any of the following for your growth, healing, and development?

- | | |
|--|--|
| <input type="radio"/> Massage/Bodywork | <input type="radio"/> Homeopathy/Herbalist |
| <input type="radio"/> Emotional Therapy/Psychotherapy | <input type="radio"/> Naturopathic Medicine |
| <input type="radio"/> Physiotherapy/Occupational Therapy | <input type="radio"/> Ayurvedic Medicine |
| <input type="radio"/> Music/Dance/Sound/Light/Aromatherapy | <input type="radio"/> Acupuncture |
| <input type="radio"/> Yoga/Pilates/Dance/Tai Chai | <input type="radio"/> Cranial-Sacral |
| <input type="radio"/> Nutritional Cleansing | <input type="radio"/> Nutritional Counseling |
| <input type="radio"/> Other _____ | |

Questions for Women

- | | | |
|--|--|--|
| <input type="radio"/> Past pregnancy | <input type="radio"/> Currently pregnant | <input type="radio"/> Breast-feeding |
| <input type="radio"/> Birth control pills/patch/ring | <input type="radio"/> Painful periods | <input type="radio"/> Irregular cycles |

Life Story

Stress Profile

Chiropractic is based upon the location and adjustment of vertebral subluxations. **Subluxations** are caused by any stress your body cannot properly perceive, adapt to, or integrate. These stresses may be physical, chemical, or emotional/mental in nature. Please circle the stresses that you've experienced as a child, teen, and adult.

Physical Stress:	Child	Teen	Adult	None	Explain
Birth Difficulty (as a Mother or Child)	C	T	A	N	_____
Serious Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
List Sports	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on Your Wallet for Years	C	T	A	N	_____
Not Enough/Poor Sleep	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Standing/Sitting	C	T	A	N	_____
Hospitalization	C	T	A	N	_____
Bone Fracture	C	T	A	N	_____
Surgery	C	T	A	N	_____
Other	C	T	A	N	_____

Emotional Stress:	Child	Teen	Adult	None	Explain
Difficult Break-Up/Divorce	C	T	A	N	_____
High Stress Career	C	T	A	N	_____
High Family Stress	C	T	A	N	_____
Money	C	T	A	N	_____
Recurrent Physical/Mental Illness	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal/Emotional Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Body Image Issues	C	T	A	N	_____
Made Fun Of/Teased	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____
Difficulty Letting Go of Control	C	T	A	N	_____
Other	C	T	A	N	_____

Chemical Stress:	Child	Teen	Adult	None	Explain
Environment (i.e. Poor Air/Water)	C	T	A	N	_____
Smoker/Second Hand Smoke	C	T	A	N	_____
High Sugar Consumption	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Energy Drinks	C	T	A	N	_____
Vaccinations	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over the Counter Drugs (i.e. Advil, etc.)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____
Alcohol Use	C	T	A	N	_____
Antibiotics	C	T	A	N	_____
Work with Chemicals	C	T	A	N	_____
Poisoning	C	T	A	N	_____
Other	C	T	A	N	_____

Nutritional Background

Nutritional History (please check the items that apply to your typical diet)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Junk food (_____ x's per week) | <input type="checkbox"/> Excess sugar | <input type="checkbox"/> Skip meals |
| <input type="checkbox"/> Microwave food (_____ x's per week) | <input type="checkbox"/> Artificial sweetener | <input type="checkbox"/> No breakfast |
| <input type="checkbox"/> Gluten-free | <input type="checkbox"/> Dairy-free | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Omnivore | <input type="checkbox"/> Raw food |
| <input type="checkbox"/> Other special diet _____ | | |
| <input type="checkbox"/> Water (# of glasses per day _____) | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tea/coffee |
| <input type="checkbox"/> Soda | <input type="checkbox"/> Energy drinks | <input type="checkbox"/> Juice |
| <input type="checkbox"/> Caffeine | | |

Do you relate any of the experiences checked above to your current state of health? y | n

If yes, which ones? _____

System Challenges

Has your body communicated any of the following to you? While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression/Nervousness |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Anemia | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Rashes/Eczema | <input type="checkbox"/> Numbness in Arms/Legs | <input type="checkbox"/> Vision/Hearing Changes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation/Diarrhea/Gas | <input type="checkbox"/> Urinary Changes | <input type="checkbox"/> Hypo/Hyper Thyroid |
| <input type="checkbox"/> Digestions Problems | <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Prostate Changes |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sweats/Chills | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Tension Between Shoulder Blades | <input type="checkbox"/> Fatigue | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Other _____ | |

Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.

1 = extremely dissatisfied. 10 = completely fulfilled.

- | | |
|-------------------------------------|----------------------------------|
| Sleep Quality _____ | Connection to God _____ |
| Energy Level _____ | Feelings of Abundance _____ |
| Clarity of Thought _____ | Level of Joy in Life _____ |
| Physical Flexibility and Ease _____ | Relationships _____ |
| Mental Flexibility _____ | Sense of Peace/Hope _____ |
| Emotional Balance _____ | Ability to Adapt to Change _____ |
| Level of Pain _____ | Overall Health & Wellbeing _____ |

Clarifying Your Intentions

What do you hope to receive from our care? (i.e. full, abundant health and well-being, pain relief, reconnection of my spiritual/physical body, etc.)

What is your level of commitment to yourself, your life, healing and wellbeing?

High | Medium | Low

Philosophical Agreement

Healing Touch Chiropractic exists to make a positive contribution in your life, by assisting you to heal naturally and to enjoy abundant health and wellbeing. **The Practice of Chiropractic** is based on ageless principles governing health and healing. They are briefly explained below so that you may understand how Chiropractic care can help you.

Innate Intelligence is the sole difference between life and death. From the moment of conception until your last breath, Innate Intelligence is the essence that sustains you. You can live for some time without food, water, sleep, exercise, and even air, yet you cannot live without Innate Intelligence. Innate Intelligence is the essential ingredient in health and healing. It is the power that runs and heals your body. **Healing** is the creation of new cells to replace old, sick, or damaged ones. Cellular replacement is how your body heals and repairs naturally. When new healthy cells are created regularly you stay well and healthy. Innate Intelligence is generated by the brain and flows through your spinal cord and nerve network to stir every tissue cell of your body into aliveness.

The **Nerve System** is also the medium used for the transfer of vital information essential for all Human Works-from healing to body functions, emotions, creativity, performance, and self-expression. Your Nerve System is your link between the inner and outer world. It consists of the brain, the spinal cord, nerves, and the neurotransmitters. The extensiveness of the Nerve System is such that your Nerve System and **Immune System** are in fact one; therefore a Nerve System at ease rather than stressed or tense, leads to a stronger immunity. Your body functions at its best.

Blockages and interferences to your **Nerve System** develop throughout life from physical, emotional, or chemical stressors. This interferes with your normal physiology. With time, dis-ease, malfunction, symptoms, sickness, and disease manifest. These symptoms are the effects rather than the cause. **Chiropractic addresses cause rather than the effects.**

A **free flow in brain to body communication** enhances your ability to heal, repair, and be healthy. When messages from your brain travel freely to all parts of your body, you express and experience life fully. Healing, wellbeing, increased performance and greater personal expression are the natural byproducts.

Chiropractic adjustments improve function and the flow of messages between the brain and body, by removing blockages and interferences to the Nerve System. It allows every individual whether a newborn, an athlete, or a grandparent to heal, repair and experience more vitality. Due to greater function, all areas of a person's life improve. In some individuals, physical, emotional and/or mental challenges may clear up quickly; in others the process is slower or partial. Yet everyone will benefit on some levels. The power of the adjustment is remarkable.

Chiropractic is not a substitute, an alternative, or a preventative form of medicine. **Chiropractic specializes in the expression of life, health, wellness, healing and wellbeing.** Medicine specializes in the diagnosis and treatment of symptoms, sickness and disease. One is not exclusive of the other; both are separate and distinct professions.

Rather than diagnose, treat or prognose any physical, mental or emotional ailments which is the practice of medicine, we free innate intelligence through adjustments. We share information and impart knowledge about natural healing, health, wellness and wellbeing, which is the practice of Chiropractic. Our primary goal is your health, healing process and wellbeing. We are here to support you.

I _____ have completely read and understood the above statement and choose to receive care.

Signature _____ Date ____/____/____

Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to use my physical address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If Healing Touch Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Healing Touch Chiropractic to use my name on a welcome board, referral board, and birthday board.
- I give permission to Healing Touch Chiropractic to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give permission to Healing Touch Chiropractic to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.
- I give Healing Touch Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.

By signing this form you are giving Healing Touch Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at Healing Touch Chiropractic more efficient and productive as well as to enhance your access to quality of Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Healing Touch Chiropractic plus 7 years unless revoked by me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Name (Print) _____

Signature _____ Date ____/____/____

Insurance Policy

Recommendations for care are based on necessity and not insurance benefits. Please understand that insurance companies pay for sick-care, not wellness care as provided by Healing Touch Chiropractic. Many times your insurance benefits may contribute to the cost of your care here at Healing Touch Chiropractic. Your insurance policy is between you and your insurance company, not between your insurance company and us. We are happy to offer to do your insurance billing for you with full understanding that the cost for service rendered to you by Healing Touch Chiropractic is your personal responsibility. If applicable, we will accurately bill your insurance company for services.

I CLEARLY UNDERSTAND AND AGREE that I am responsible for all bills incurred at this office relating to my care. I also understand that I may suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable. I agree that if I fail to provide Healing Touch Chiropractic with payments made in my name for services rendered at Healing Touch, I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I _____ have completely read and understood the above statement concerning insurance and choose to receive care.

Signature _____ 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 care and follow up with multiple healthcare providers who may be involved in that care.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understood your Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Name (Print) _____

Signature _____ Date ____/____/____