



Welcome to our Office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you.

“Our mission at ALC is to assist the vital health of our community by allowing families to reach their full potential through chiropractic care.”

About the Patient

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____
Cell Phone (____) _____
Birthdate ____/____/____ Age _____
Gender Male Female # of Children _____
Employer _____
Work Address _____
Work Phone (____) _____
Type of Work _____
Marital Status Married Single Divorced
 Separated Widowed
SSN _____
Email _____

About the Spouse or Parent

Name _____
Home Phone (____) _____
Employer _____
Work Address _____

Reason for This Visit

Describe the purpose of this visit: _____

Is the purpose of this appointment related to:

- Work Sports Auto Fall
 Chronic Discomfort Home Injury Other

Explain _____

If work related, have you made a report of your accident to your employer? YES NO

When did this condition begin? _____

Has this condition gotten worse stayed constant
 comes and goes

Does this condition interfere with
 Work Sleep Daily Routine Other

Explain _____

Has this condition occurred before? YES NO

Explain _____

Have you seen other doctors for this condition?
 YES NO

Doctor's Name(s) _____

Type of Treatment _____
Results _____

Experience with Chiropractic

Who referred you to this office? _____
Have you been adjusted by a chiropractor before? YES NO
Reason for those visits _____
Doctor's Name _____
Approximate date of last visit _____
Has any *adult* in your family seen a chiropractor? YES NO If yes, who? _____
Has any *child* in your family seen a chiropractor? YES NO If yes, who? _____

Awareness of Chiropractic Principles

Were you aware that...

- Doctors of Chiropractic work with the nervous system? YES NO
- The nervous system control all bodily function and systems? YES NO
- Chiropractic is the largest natural healing profession in the world? YES NO
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? YES NO

Financial Agreement

I, _____, clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the 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 to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

Patient Signature

Date

Guardian or Spouse Signature

Date

Who should receive bills for payment on your account?

- Patient Spouse Parent Worker's Comp.
 Medicare Personal Health Insurance Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name _____
Relationship _____
Work Phone (____) _____
Home Phone (____) _____
Cell Phone (____) _____

My Health Insurance

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 provide an 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 upon receipt.

Insurance Company _____
Address _____
Phone # (____) _____

Policy # _____
Group # _____

About the Insured Person

Name _____
Relation _____

Insured's SSN _____
Date of Birth ____/____/____

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Fee</u>
Consultation	\$ 30
Initial Exam/Computer Scans	\$ 125
Dynamic Re-exam/Computer Scans	\$ 40
X-Rays	\$ 75
Adjustments	\$ 50
Wellness Adjustment Plans	?

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstanding in the future. Our main concern is your health and well being, and we will do our best to help you.

IMPORTANT: All client's, are responsible for full payment for the first visit, unless other arrangements have been made in advance.

Today's payment will be made by: Cash Check Credit Card

Insurance: We will verify all insurance and your benefits per your agreement with you carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. *Please let the Chiropractic Assistant know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.*

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Abundant Life Chiropractic with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Patient's Name

Patient's Signature

Date: ____/____/____

Witness

Missed Appointment Policy

Here at Abundant Life Chiropractic, we strive to provide you with the utmost professionalism and excellence of service. Our commitment to your health and well-being is something we take very seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need, and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment please call our office and arrange for a make-up appointment with our Chiropractic Assistants. We would prefer the make-up appointment be within the same week.

In the instance of a rescheduled appointment, or a no show without notice by phone we reserve the right to charge you a \$20.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all of the information written above.

Patient's Name

Patient's Signature

Date: ____/____/____



INFORMED CONSENT FOR CHIROPRACTIC

ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic (**Dr. Cory Sartin, Dr. Dani Sartin**) and/or his/her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, Abundant Life Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with information that provides a more complete description of information uses and disclosures. I understand that I have the right to review this information prior to signing this consent. I understand that Abundant Life Chiropractic reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Abundant Life Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Abundant Life Chiropractic has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Printed)

Date Signed

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Witness to Signature

Doctor of Chiropractic Signature

Date Signed

Goals for My Care

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

- Relief Care:** Symptomatic relief of pain or discomfort
- Corrective Care:** Correcting and relieving the cause of the problem, as well as, the symptoms
- Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- Doctor's Recommendation:** I would like the Doctor to select the appropriate type of care for my condition.

 Patient's Signature

 Date

Medications I Currently Take

- | | |
|---|---|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Pain Killers (including Aspirin) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> _____ |

Health Habits

- | | | |
|----------------------------|--------------------------------------|--|
| Do you smoke? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you drink alcohol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you drink coffee? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you exercise regularly? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you wear | <input type="checkbox"/> heel lifts | <input type="checkbox"/> sole lifts |
| | <input type="checkbox"/> inner lifts | <input type="checkbox"/> arch supports |

Health Conditions

Please check each of the disease or conditions that you have had now or 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.

- | | | |
|--|--|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Numbness or Pain in Arms/Legs | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Heart Attack/Stroke | | |

For Women Only:

- | | | | |
|------------------------------------|------------------------------|-----------------------------|-----------------------|
| Are you pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | How many weeks? _____ |
| Are you nursing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Are you taking birth control? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Do you experience painful periods? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Do you have irregular cycles? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Do you have breast implants? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

STRESS TEST

Each of us has had stress from birth to the present time, and will continue to have stress as long as we are alive. Please circle when you have experienced these various stressors no matter how mild or severe, or how often your exposure(s) may have been.

C (child) **T** (teenager) **A** (adult) **N** (none)

I. PHYSICAL STRESS

EXPLAIN

- | | | | | | |
|---|----------|----------|----------|----------|--|
| <input type="radio"/> Birth Trauma (mother or child) | C | T | A | N | |
| <input type="radio"/> Slips/Falls | C | T | A | N | |
| <input type="radio"/> Car Accidents | C | T | A | N | |
| <input type="radio"/> Sports Injuries | C | T | A | N | |
| <input type="radio"/> Physical Abuse | C | T | A | N | |
| <input type="radio"/> Work Injuries | C | T | A | N | |
| <input type="radio"/> Poor Posture | C | T | A | N | |
| <input type="radio"/> Sitting on your wallet | C | T | A | N | |
| <input type="radio"/> Sleep Position – stomach | C | T | A | N | |
| <input type="radio"/> Extensive Computer Work | C | T | A | N | |
| <input type="radio"/> Carrying Heavy Purse/Backpack/Child | C | T | A | N | |
| <input type="radio"/> Repetitive Lifting/Bending | C | T | A | N | |
| <input type="radio"/> Driving for Many Hours | C | T | A | N | |
| <input type="radio"/> Continuous Hours Sitting/Standing | C | T | A | N | |
| <input type="radio"/> Bone Fracture/Surgery | C | T | A | N | |

II. EMOTIONAL STRESS

- | | | | | | |
|---|----------|----------|----------|----------|--|
| <input type="radio"/> Relationships | C | T | A | N | |
| <input type="radio"/> Career | C | T | A | N | |
| <input type="radio"/> Children | C | T | A | N | |
| <input type="radio"/> Money | C | T | A | N | |
| <input type="radio"/> Fast-Paced Life | C | T | A | N | |
| <input type="radio"/> Hold in Feelings | C | T | A | N | |
| <input type="radio"/> Quick Tempered | C | T | A | N | |
| <input type="radio"/> Verbal Abuse | C | T | A | N | |
| <input type="radio"/> Perfectionist | C | T | A | N | |
| <input type="radio"/> Procrastinator | C | T | A | N | |
| <input type="radio"/> Sickness or Loss of Loved One | C | T | A | N | |

III. CHEMICAL STRESS

- | | | | | | |
|---|----------|----------|----------|----------|--|
| <input type="radio"/> Environment (ie. pollution) | C | T | A | N | |
| <input type="radio"/> Smoker or Second Hand Smoke | C | T | A | N | |
| <input type="radio"/> Poor Diet | C | T | A | N | |
| <input type="radio"/> Caffeine | C | T | A | N | |
| <input type="radio"/> Excessive Sugar | C | T | A | N | |
| <input type="radio"/> Artificial Sweeteners | C | T | A | N | |
| <input type="radio"/> Prescription Drugs | C | T | A | N | |
| <input type="radio"/> Over-the-counter Drugs | C | T | A | N | |

IV. Which do you feel is your primary stress? (Circle) **Physical Emotional Chemical**

Please Explain: _____

INITIAL CONSULTATION FORM

PLEASE COMPLETE PRIOR TO CONSULTATION & EXAM

Patient's Name: _____ Date: ____/____/____

Primary Complaint(s):

Please select the appropriate response

Overall **frequency** of the complaint:

Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%)

Overall **intensity** of the complaint:

Minimal (an annoyance but no effect on activity) Moderate (tolerable with marked impairment of activity)
 Slight (tolerable with some impairment to activity) Severe (intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

Does it interfere with you normal daily activities? (family, recreation, sports)

Do your symptoms increase while performing you normal work duties? YES NO

If yes, please circle the amount below that you feel your symptoms increase at work:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What aggravates the problem:

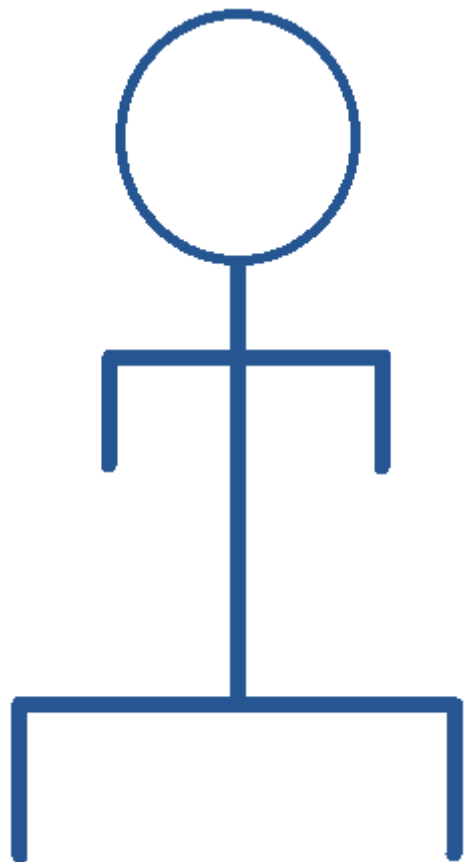
What relieves the problem:

If this problem went without being taken care of, how do you think it would affect you?

Patient Signature _____ Date ____/____/____

FOR DOCTOR'S USE ONLY

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EXAM FINDINGS

HISTORY