FAMILY CHIROPRACTIC & Wellness

Reclaim your health.

Date:_____ **What's your color personality? Red Yellow Blue Green**

Name_____ ***How did you hear about us?***_____

SSN_____ Date of Birth_____ Age_____ Gender M or F

Address_____ City_____ State_____ Zip_____ Marital Status_____

Home or Cell Phone:_____ Email_____ # Children_____

Occupation_____ Employer:_____ Work Phone_____

Spouse's Name:_____

If you have insurance, please present your card(s) to the office manager for processing.

Have you seen a Chiropractor in the Past? □Yes □No If Yes, when was your most recent visit?_____

Why did you see the Chiropractor?_____ Doctor's Name?_____

What frequency was prescribed for your ongoing maintenance care?_____

Why did you discontinue care?_____

When was your most recent set of spinal x-rays?_____

Who is your Primary Medical Physician? _____ Clinic name/Phone_____

Current Health Information:

Describe your main complaint:_____

_____

Secondary complaints:_____

How long have you suffered with this?_____ **Have you had similar symptoms in the past**? □Yes □No

How did your symptoms begin? □Work Injury □Auto Accident □Other(describe):_____

Have you seen any other doctor(s)/therapists for this condition? □ No □Yes **Who?**_____

What gives you some temporary relief?_____

What aggravates your condition?_____

Progression (circle): Improving Not-Improving Worsening

How severe are the symptoms.	NONE	<1	2	3	4	5	6	7	8	9	10>WORST
Rate your current level of stress.	No stress	<1	2	3	4	5	6	7	8	9	10> Extremely Stressed
Rate your current overall health.	Very Unhealthy	<1	2	3	4	5	6	7	8	9	10> Optimal Health

Are you pregnant? □Yes □No Date of Last Period_____

What is your current exercise routine?_____

How is your diet, and do you take any supplements?_____

Where on your body do you hold or carry your stress?_____

What tools have you used to try to reduce your stress?_____

How many hours do you sleep each night and do you have difficulty falling asleep?_____

How much do you prioritize your health?_____

Past Health History:

Please list any hospitalizations or surgical operations and state the years:_____

_____

Please describe any previous traumas and years:

□ Motor Vehicle Accidents_____ □ Sports Injuries_____

□ Work Injuries_____ □ Falls_____

□ Childhood traumas_____ □ Birth Injuries_____

How do you want us to handle your problem?

*There are three levels of Chiropractic care; I am interested in the following level of Health Care (**check one**):*

□ Acute Health Care/ Temporary Relief (Help the symptom but do not fix the cause of the problem.)

□ Corrective Health Care (Eliminate the underlying issue and reduce likelihood of recurrence.)

□ Wellness Health Care (Optimize the functioning of my body, to live a more vibrant life with optimal health.)

Why did you come into our clinic and what are your expectations of us?_____

_____

Semi-open Room Adjusting Consent

At Family Chiropractic & Wellness we utilize semi-open room adjusting. This environment will have many benefits for our patients including; a sense of warmth, increased education, excitement and energy. During your adjustments, we will not go over private information; however you will be in an area where others may see you or overhear conversation. When you wish to discuss a private matter with the doctor, please notify a team member or the doctor so you may be seen in a private adjusting room. This environment is not used for providing exams, presenting report of findings, or consultations. These procedures are all completed in a private, confidential setting.

➡ Signature_____

Light and Sound Release

1. I agree to release PorterVision, LLC, its officer, directors, employees and agents from all liability for damage and injury to myself or to my property arising from whatever cause from my use of any and all “light and sound” equipment… i.e. ZenFrames, BrainFit, etc., accepting myself the full responsibility for any and all such damage or injury.

2. I understand that the “light and sound” equipment is not suitable for all applications.

3. I acknowledge that I do **not** have a history of seizures nor do I have photosensitive epilepsy.

4. I acknowledge that I do not have a history of Hallucinations.

5. I acknowledge that I have read this release of liability and agree to the terms and conditions.

➡ Signature_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem. Your doctor will then be able to recommend what type of care you need to achieve balance…Where are your loved ones?

BALANCED NERVOUS SYSTEM

□ High Energy □ Few Symptoms □ Resistant to Infections □ Positive Mental Attitude
□Mentally Alert □Excellent Health □Active □Vibrant

UNBALANCED NERVOUS SYSTEM

UNDER-AROUSED
- □ Poor Attention
- □ Impulsive
- □ Easily Distracted
- □ Disorganized
- □ Depressed
- □ Lacking Motivation
- □ Poor Concentration
- □ Spaciness
- □ Constipation
- □ Low Pain Threshold
- □ Difficulty Waking Up
- □ Worry
- □ Irritable
- □ Low Energy

UNSTABLE
- □ Migraines
- □ Headaches
- □ Seizures
- □ Sleepwalking
- □ Hot Flashes
- □ PMS
- □ Food Sensitivities
- □ Bed Wetting
- □ Eating Disorders
- □ Bipolar Disorders
- □ Mood Swings
- □ Panic Attacks

OVER-AROUSED
- □ Cold Hands
- □ Cold Feet
- □ Tight Muscles
- □ Teeth Grinding
- □ Anxiety
- □ Heart Palpitations
- □ Restless Sleep
- □ Poor Expression of Emotions
- □ Racing Mind
- □ High Blood Pressure
- □ Accelerated Aging
- □ Irritable Bowel

EXHAUSTED NERVOUS SYSTEM

□ Cancer □ Rheumatoid Arthritis □ Diabetes □ Multiple Sclerosis □ Depression
□ Chronic Fatigue Syndrome □ Fibromyalgia □ ALS □ Epstein-Barr Syndrome

Consent to Treat

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. **Chiropractic** is a licensed health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.
B. **The Practice of Chiropractic** focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.
C. **Chiropractic evaluation and examination** is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs. Doctors of Chiropractic focus particular attention on prevention and correction of **Subluxation**.
D. **Subluxation** (particularly of the spine) is a complex of alignment, movement and/or pathological joint abnormalities that chokes off or compromises nerve integrity causing abnormal organ system function and ill health.
E. **Chiropractic Adjustment** is a very specific manipulation, only performed by licensed chiropractors, to eliminate **Subluxation** and allow normal nerve function and health restoration. Chiropractic Adjustments are safe, effective procedures applied over one-million times each day in the United States alone.
F. **Prevention of Subluxation** is accomplished through **maintenance adjustments** and nutritional, mental, and physical wellness habits taught and prescribed by Doctors of Chiropractic.
G. **We invite you to speak frankly to the doctor or staff** on any matter related to your care at our office. We work to maintain as a supporting, open environment.
H. We do not seek to replace or compete with medical, dental or other type(s) of health professionals and will provide referral for other evaluation if the doctor feels it is the best interest of his patient. Those providers retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.
I. **Your compliance** with Chiropractic Adjustment schedules and instructions is essential to maximum healing and optimal health through Chiropractic. We will work diligently to help you meet your Chiropractic needs.

I understand all of the above information and give consent for the chiropractic evaluation and care to be performed by Dr. Michael G. Jorgensen.

Patient's Signature_____ **Date** _____

Thank you for choosing Family Chiropractic and Dr. Michael for the sake of your health.

Version: 8.8.2016