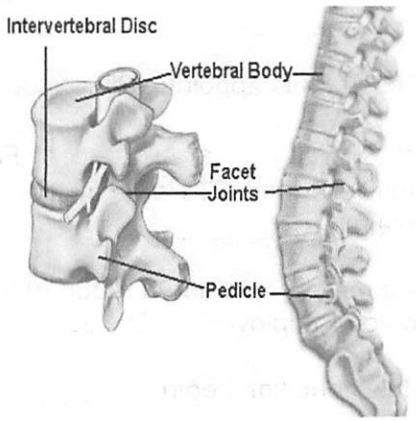

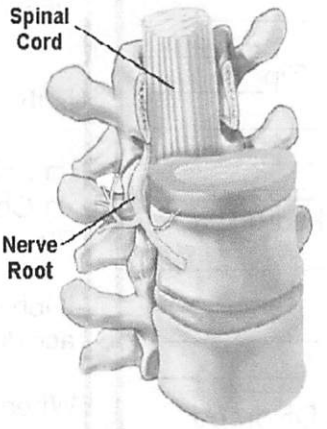

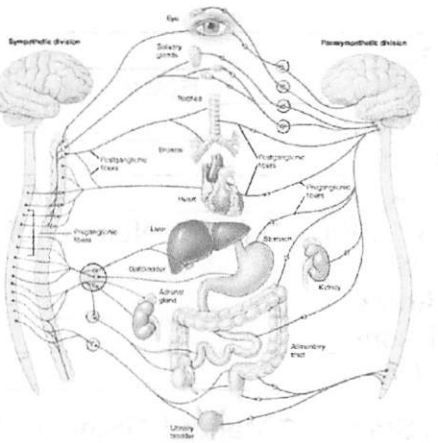

NeuroEdge

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 commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About the Patient

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____
Cell Phone (_____) _____
Birthdate _____ Age _____
Gender ❒M ❒ F Number of Children
Employer _____
Work Address _____
Work Phone _____
Type of Work _____

Marital Status ❒Married ❒Single ❒ Divorced
❒Separated ❒ Widowed

Email Address _____

Social Security # _____

Payment Method ❒ Cash ❒ Check ❒ Credit

Card CC# _____ Exp: ___/_____

About the Spouse or Parent

Name _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____

Reason For This Visit

Describe the purpose of this visit: _____
_____

Is the purpose of this appointment related to:

❒ Job ❒ Sports ❒ Auto ❒ Fall
❒ Chronic Discomfort ❒ Home Injury ❒ Other
Please explain _____

If job 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 activities
Please explain _____

Has this condition occurred before? ❒ Yes ❒ No
Explain _____

Have you seen other doctors for this condition?
❒ Yes ❒ No

Dr.'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
Has any *child* in your family seen a Chiropractor? ❒ Yes ❒ No

Awareness of Chiropractic Principles

Were 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
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❒ Yes ❒ No

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.

❒ I want the Doctor to select the type of care appropriate for my condition.

_____

Patient's Signature Date

Medications I Now Take

❒ Nerve Pills
❒ Pain Killers (including Aspirins)
❒ Muscle Relaxers
❒ Blood Pressure Medicine
❒ Insulin
❒ Stimulants
❒ Blood Thinners
❒ Tranquilizers
❒ _____
❒ _____

Health Habits

	No	Yes
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒
Do you drink coffee?	❒	❒

Do you exercise regularly? ❒ No ❒ Moderate ❒ Daily

Do you wear ❒ Heel Lifts ❒ Sole lifts ❒ Inner Soles ❒ Arch Supports

HEALTH CONDITIONS

Please check each of the diseases 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.

❒Severe or Frequent Headaches
❒Sinus Problems
❒Dizziness
❒Cancer
❒Loss of Sleep
❒Hepatitis
❒Pain Between the Shoulders
❒Frequent Neck Pain
❒Numbness or Pain in
❒Arms/Legs/Hands
❒Lower Back Problems
❒Digestive Problems
❒Ulcers/Colitis
❒Heart Attack/Stroke
❒Thyroid Problems
❒Kidney Problems
❒Congenital Heart Detect
❒Heart Surgery/ Pacemaker
❒High/low Blood Pressure
❒Psychiatric Problems
❒Difficulty Breathing
❒Rheumatic Fever
❒Asthma
❒Arthritis
❒Alcohol/Drug Abuse
❒Venereal Disease
❒HIV/AIDS
❒Diabetes
❒Tuberculosis
❒Shingles
❒Chemotherapy
❒Anemia

FOR WOMEN ONLY:

Are you pregnant? ❒Yes ❒No

Are you nursing? ❒Yes ❒No

Are you taking birth control? ❒Yes ❒No

Do you experience painful periods? ❒Yes ❒No

Do you have irregular cycles? ❒Yes ❒No

Do you have breast implants? ❒Yes ❒No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

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 rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient Signature Date Guardian or Spouse's Signature Date

Who should receive bills for payment on your account?

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

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home 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 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 upon receipt.

Insurance Company _____ Policy #_____
Address_____ Group # _____
Phone Number_____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security #_____
Relation _____ Date of Birth _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Neuroedge Chiropractic.

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

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Neuroedge Chiropractic to perform such. 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's Name (Please Print) **Date**

_____

Patient or Guardian's Signature

Office Policies & Procedures

please initial highlighted

_____1. **Symptoms:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

_____2. **Appointments**: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness and avoid being charged a $20 fee. It is your responsibility to get here. We will do all we can to accommodate you.

_____3. **Dynamic Examinations**: During your Initial Intensive Care you will receive several Dynamic Examinations to monitor your level of spinal correction. On this visit, you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending approximately 30 extra minutes on these days. Immediately following your Dynamic Examination, the doctor will sit down with you to discuss your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

_____4. **Exercise:** Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, disks, and nerves. However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced. We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

_____5. **Nutrition**: Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs on a daily basis.

_____6. **Results:** We are very results oriented, however many factors that we have no control over affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

PATIENT: _____ DATE: _____

WITNESS: _____

Congratulations on choosing Chiropractic. Follow through with your family, and enjoy the health benefits that come with a Chiropractic lifestyle.