NEUROEDGE CHIROPRACTIC

Name_____ Cell Phone_____

Address_____City_____ State_____ Zip Code_____

Date of Birth _____/_____/_____ Male/Female Age _____

Email_____ SS# _____

Number of Children _____ Name of Children_____

Employer _____

Type of Work _____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

1. Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office? _____

2. Science tells us your spine like your teeth need to be cared for regularly. How often do you get adjusted by a chiropractor? Frequently / only when I hurt / 1x a month

3. When was your last complete spinal examination including x-rays? _____

4. Do you know if you have a ☐spinal curvature ☐spinal arthritis ☐inherited spinal problem

5. Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back as well as loss of nerve health. Do you hear these sounds when you move your head or neck? ☐Yes ☐No

6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐Yes ☐No

7. Poor posture leads to poor health and early death. How would you rate your posture?

   Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months

   None 1 2 3 4 5 6 7 8 9 10 Intense

9. Please circle or list any health symptoms or health complaints you are experiencing.

Neck pain L/R	Leg pain L/R	Heart Disease	Thyroid
Mid back pain	Asthma	Cancer	Allergies:
Low back pain	Headaches/Migraines	Constipation	
Arm pain L/R	Diabetes I/II	Menstrual pain	

10. Prescription medications cause various side effects and hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? 1)_____ _____ 2) _____ 3) _____ 4) _____

11. Please list any surgeries you have had. _____

12. Do you smoke? ☐Yes ☐No

13. Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant? ☐Yes ☐No

14. Daily trauma, auto accident(s) and work injuries can cause misalignment of vertebrae and serious spinal problems. When was your most recent injury at home?_____ Car accident?_____ Slip or fall? _____

15. Improper sleeping positions can cause spinal misalignment and spinal damage. What sleeping position do you sleep in: ☐Back ☐Stomach ☐Ride Side ☐Left Side

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often

17. Are you? ☐Right handed ☐Left handed

18. Please list vitamins/supplements you take:_____

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? ☐Yes ☐No

    The above info is true and accurate to the best of my knowledge.
    Patient Signature (Parent/Guardian):_____ Date:_____

Authorization For Care

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

I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills insured 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 assignments of my insurance rights and benefits (if applicable) directly to provider of services rendered.

X _____ X _____

Patient Signature Guardian Signature

Who should receive bills for payment on your account?

☐Patient ☐Spouse ☐Parent ☐Work Comp ☐Medicare ☐Personal Health Insurance ☐Auto Insurance

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_____
ID #_____
Group #_____
Address _____
Phone Number _____

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.

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

Marty Carlson D.C.
25032 Las Brisas Rd. Unit A
Murrieta, Ca. 92562
951-304-2242
mcarlsondc@yahoo.com
www.neuroedgechiropractic.com

Print Full Name: _____

Credit Card Authorization

I, _____, give authorization to Neuroedge Chiropractic to charge my card in the amount of $20 for any missed appointments or canceled appointments without a 24 hour notice. I acknowledge that I am legally responsible for any and all charges and I authorize my card to be charged the total of any back balance if I decide to discontinue my care.

( ) Visa ( ) Master Card

Card Number: _____
Expiration Date: _____
Security Code (3 digits): _____

Signature: _____ Date: _____