



Rock Chiropractic Leander
A Family Chiropractic Center

Date: _____

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: home(____) _____ work(____) _____ cell:(____) _____

Social Security #: _____ Email: _____

Circle one: Male/Female ~ Single/Married/Divorced/Widowed ~ Preferred contact: Home/Cell/Work

Your occupation & employer: _____

Spouse's Name: _____ Children's names/ages: _____

Reason for consulting our office? _____

Date this issue began? _____ Who may we thank for referring you to our office? _____

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in you lifetime, allowing us to better assess the challenges to you health potential.

Please list you interest regarding your health and this visit. Please check one: ___chiropractic ___complete wellness (initial)___

The Beginning Years

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

The Childhood Years

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Were you involved in any car accidents as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any serious falls as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Was there any prolonged use of medicine (antibiotics)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you play youth sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Were you vaccinated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you take/use any drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did you suffer any other traumas (physical/emotional)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any surgery?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	As a child, were you under regular chiropractic care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you fallen/jumped from a height over 3 feet? (ie. Crib, bunk bed, trees)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

YES NO UNSURE

YES NO UNSURE

Do/did you smoke? YES NO UNSURE
 Do/did you drink alcohol? YES NO UNSURE
 Have you been in any accidents? YES NO UNSURE
 Have you had any surgery? YES NO UNSURE

Do/did you play any adult sports? YES NO UNSURE
 Do/did you participate in extreme sports? YES NO UNSURE
 On a scale of 1-10, describe your stress level:
 (1=none/10=extreme)
 Occupational _____
 Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Addressing The Issues That Brought You To The Office

If you have any symptoms or complaints, and are here for wellness services, please check here ____ "Wish to have Chiropractic Services" and skip to "Family Health Profile." Others need to briefly describe the chief area of complaint, including the effect it has had on your life. _____

If you are experiencing pain, is it... Sharp Dull Comes and goes Travels Constant
 Since the problems started, is it... About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

Chiropractor _____
 Medical Doctor _____
 Other _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Pins and needles in legs	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Pins and needles in arms	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Back pain	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Tension
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Neck stiff	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Fever	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Problems urinating	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Ulcers

List any medications you are taking: _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____
 Spouse: _____
 Mother: _____
 Father: _____
 Brothers: _____
 Sisters: _____
 Others: _____

Have you ever:

Bought bottled water Consumed vitamins or supplements Belonged to a health club

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluations(init): _____.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Office Fee Schedule and Financial Policy

Service

Consultation	No Charge
Initial Visit	\$79-\$168

Your initial visit includes

Consultation	No Charge
Posture Analysis/Spinal Evaluation	\$28
Thermography/SEMG	\$30
X-ray (if necessary)	\$110
Chiropractic Report	No Charge

Dynamic Exam	\$30
Adjustment	\$45
Insurance Reports	\$50-\$125

Financial Policy and Chiropractic Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service rendered unless you arrange an Active Life Plan in advance. Active Life Plans include Corrective Adjustment Plans (CAP), Wellness Adjustment Plans (WAP), or Family Adjustment Plans (FAP). These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

- **Health Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis, and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and every Wednesday thereafter. Just send in your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

I have read and I understand the above policies.

Patient Signature

Date