Wellness Within
Chiropractic

First Name:_____ Last Name:_____

Date: _____ Cell Phone: _____ Home phone: _____

Street address:_____

City: _____ State:_____ Zip: _____

Age: _____ Birthdate: _____ Occupation: _____

Sex: Male Female Other Are you: Single Married Widowed Separated Divorced

Who referred you to this office? _____

PARENTAL CONSENT TO EVALUATE & TREAT A MINOR

I _____ being the parent/guardian of

_____ hereby grant permission for my child to receive chiropractic care.

Witness: _____

CONSENT TO INITIATE CARE

At our office, we have one simple goal- we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate.

- You may choose to submit receipts to your insurance company or other third-party healthcare programs but payment for such services by the insurance company is neither implied or agreed to buy this office. We take *no responsibility* for non-payment by insurance companies for services rendered in this office.
- Our office will not respond to requests for paperwork for insurance purposes or even acknowledge requests for any patient's case. However, patients may have a copy of their records.
- No balances can be kept or run by any patient at any time.
- All adjustment visits are paid immediately after services are rendered.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the consent to initiate care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Name:	
Date:	Signature:

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SOME QUESTIONS TO HELP US HELP YOU

Name: _____ Date: _____

If we could only help you with one health problem, what would that be?

_____

What other health problems would you like us to help you with?_____

_____

How did these problems start? _____

_____

When did they begin? _____

Have you ever had these problems before? _____

Is it worse in the morning or at night? _____ Morning or _____ Night

Do you ever have numbness, tingling or pain in the arms/hands legs/feet?_____

How often do you feel the pain and how long does it last? _____

Please list any other doctors seen for the above problem: _____

Current medications: _____

Any surgeries: _____

Please list any auto or work accidents you've had:_____

Any family history of (circle): Stroke heart disease diabetes cancer

Do you get any dizziness? _____ Do you have heart, lung or stomach problems? _____

Right or left handed? _____ Height: _____ Weight: _____

Name of previous chiropractor? _____

When were the last x-rays of your spine taken? _____

Are you looking for temporary relief or do you want to fully correct the cause of your problem?

_____

Why? _____

What activities or hobbies have you been unable to do because of your problem? _____

_____

Name: _____ Date: _____

MUSCULO-SKELETAL SYSTEM

_____Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints

_____ Sore muscles
_____ Weak muscles
_____ Walking problems

_____ Ruptures
_____ Broken bones

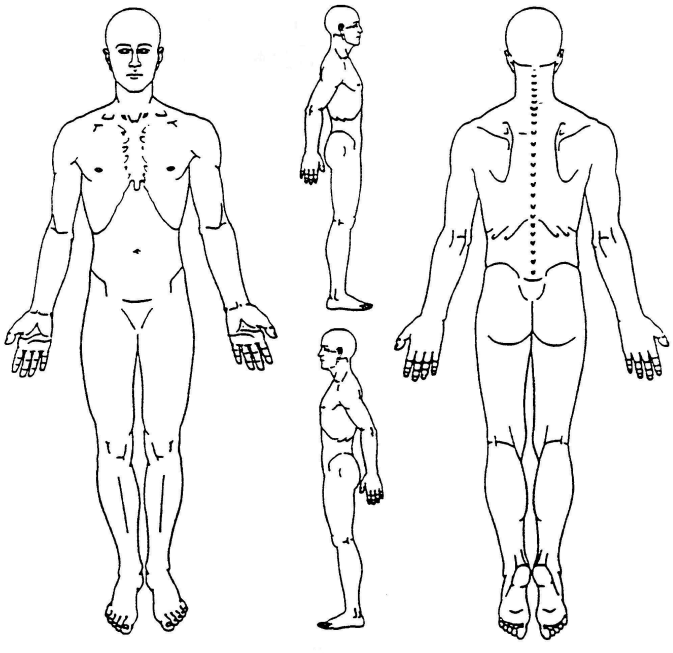
Please mark the picture below with

EYES, EARS, NOSE THROAT

_____ Eye strain
_____ Eye inflammation

_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing Loss
_____ Ear discharge
_____Nose pain

_____ Nose bleeding
_____ Nose discharge
_____ Difficulty breathing through nose
_____ Sore gums
_____ Dental Problems
_____ Sore Mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____Excessive hunger

_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood

_____ Abdominal pain
_____ Diarrhea
_____ Constipation

_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gallbladder problem
_____ Weight trouble

GENITO-URINARY SYSTEM

_____Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

CARDIO-VASCULAR RESPIRATORY

_____ Chest pain
_____ Pain over heart

_____ Difficult breathing
_____Persistent cough
_____Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problem
_____ Heart problems
_____ Lung problems
_____ Varicose veins

NERVOUS SYSTEM

_____Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches

_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

Any chance you could be pregnant? YES NO

Due Date: _____

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WORK INJURY AND AUTOMOBILE INJURY NOTICE
AND
PURPOSE OF AN ADJUSTMENT DISCLOSURE

By signing below, I acknowledge that I am aware that Wellness Within Chiropractic and Dr. Suzanne Carrillo **DO NOT** provide care for work related injuries, automobile accident injuries, or personal injuries. I also acknowledge that I must inform this office if I am in an automobile or work related injury and must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I also am completely aware that Wellness Within Chiropractic and Dr. Suzanne Carrillo **WILL NOT** bill, submit claims nor prepare or submit reports for any automobile , personal or work related injury. I also understand that I am responsible to pay each visit myself at the time of service.

Further, I understand that chiropractic care is given to correct misalignments of the spine called **SUBLUXATIONS**. One of the benefits of a chiropractic adjustment is that you MAY feel better but this is not the **GOAL** of an adjustment. The goal of an adjustment is to correct **SUBLUXATIONS**, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, **WE DO NOT TREAT PAIN OR DISEASE**; we remove subluxations so the body is able to function properly and be better enabled to heal itself.

Name:	
Date:	Signature:

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CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with this office, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to: people in your home or other environments who can access your phone, or other devices, your employer (if you use your work email), third parties on the Internet such as server administrators and others who monitor internet traffic.

I consent to allow Wellness Within Chiropractic and Dr. Suzanne Carrillo to use unsecured (unencrypted) email and mobile phone text messaging for appointments, reminders, and the use of Square for appointments, billing and payment services. On occasion, Dr. Carrillo may forward reminders of home exercises or activities and general information about the office (change in hours etc.)

Please speak to Dr. Carrillo if you would like to **opt out**.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. *I understand that I am not required to sign this agreement in order to receive treatment.* I also understand that I may terminate this consent at any time.

Name:	
Date:	Signature:

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Orientation Quiz

1. Symptoms are the _____ thing to show up and the _____ thing to go away.

2. When a bone in the spine moves out of place and affects nervous system function, that is is called a S_____

3. What causes Subluxations? _____

4. What are the 3 main types of stress? _____

5. The ONLY thing a Doctor of Chiropractic does is detect and correct _____

6. When a Chiropractor moves a bone back into alignment, that is called an _____

7. Who can benefit from Chiropractic care? _____

8. How often should you get your spine checked for subluxations? _____

9. Anything that is good for your health requires _____ and _____. Chiropractic requires _____ and _____.

I have listed any medical conditions, diseases, pains and symptoms on the intake forms that accompany this quiz. I understand that this office CAN NOT treat me for these things and I hereby certify that I am going to seek care in a medical doctor's office for any medical problems, pain or symptoms I may have now or in the future. I am here in a Chiropractor's office for the sole purpose of getting my spine checked once every 7-10 days to detect and correct subluxations, to remove the interference between the brain and the body so that I can more fully express my innate potential, live my life more fully and become a brighter light in this world.

Name:	
Date:	Signature:

WELLNESS WITHIN CHIROPRACTIC INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin used for major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____Signature:_____ Date: _____

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Name: _____ Date: _____

1. What steps have you taken in the past to maintain your health?

- ☐ Chiropractic
- ☐ Traditional medical care
- ☐ Medications
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Physical Therapy
- ☐ Mental Health counseling
- ☐ Emergency room
- ☐ Massage
- ☐ Vitamins
- ☐ Acupuncture
- ☐ Other_____

2. How effective were the methods you used before?

- ☐ Great results
- ☐ Some results
- ☐ Made it worse
- ☐ Nothing changed
- ☐ Did not get worse
- ☐ Temporary relief
- ☐ Verdict is still out
- ☐ Unsure

3. How has your health condition affected others?

- ☐ No one has noticed
- ☐ No one is affected
- ☐ They tell me to do something about it
- ☐ They avoid me

4. Are there particular areas of concern regarding what this could be starting to impact or will impact?

- ☐ Work
- ☐ Relationships
- ☐ Finances
- ☐ Outlook on life
- ☐ Kids
- ☐ Time
- ☐ Sleep Quality
- ☐ Happiness
- ☐ Freedom
- ☐ Things you are able to do in the future

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5. Are there conditions you are scared this might turn into?

- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Disc problems
- ☐ Nerve problems
- ☐ Permanent loss of function
- ☐ Long-term pain
- ☐ Needing surgery
- ☐ Carpal Tunnel
- ☐ Complete loss of function

6. How has your health condition affected your job, relationships, finances, family or other activities? Please give examples:

_____

_____

_____

7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Please give 3 examples:

1. _____
2. _____
3. _____

8. Where do you picture yourself in the next 1-3 years if this problem is not taken care of? Please be specific.

_____

_____

9. What would be different/better without this problem?

_____

_____

10. What do you desire most to get from working with this office?

_____

11. What would it mean to you if we could help you?

_____

12. What do you do to manage stress?

- ☐ Nothing really
- ☐ Go to the gym
- ☐ Go for a walk/hike
- ☐ Sports
- ☐ Craft projects
- ☐ Art Projects
- ☐ Drink alcohol
- ☐ Journal
- ☐ Play with pets
- ☐ Other_____
- ☐ Get massages
- ☐ Social worker/Therapist/Counselor
- ☐ EFT Tapping
- ☐ Meditation
- ☐ Eat junk food
- ☐ Yoga
- ☐ Listen to music
- ☐ Read
- ☐ Breathing techniques

13. What are your general health goals? (What really matters to you?)

- ☐ Feel good
- ☐ Move better
- ☐ Function better
- ☐ Increased vitality
- ☐ Increase longevity
- ☐ Look better
- ☐ Reduce stress
- ☐ Prevent future problems
- ☐ Help current problems
- ☐ Get better so I can take care of someone else
- ☐ Feel better so I can keep up with friends & family
- ☐ Thrive instead of just surviving
- ☐ Looking for a natural way to maintain health
- ☐ Desire to reduce healthcare costs over your or your family's lifetime
- ☐ Spend time with family & friends instead of at doctor's appointments
- ☐ Show your family how much you care about them by maintaining your own health
- ☐ You wish to join our community that values vitality, independence, freedom, whole body health and be nurtured by that community
- ☐ Retain your youth
- ☐ Be healthier than other people your age
- ☐ You want to increase your productivity, energy, and focus
- ☐ To be an example to other people on how to be healthy
- ☐ You want to be a part of the community uplift that occurs when people are healthy and happy
- ☐ Other