We understand our initial paperwork may be a bit comprehensive, but you will only need to fill out forms ONCE in our office for any service in the future including massage work, lifestyle coaching, fitness/bodywork, nutrition and chiropractic care.

Today's Date: _____ **Job title: _____**

Patient Name: _____ **Type of Work: _____**

Address: _____ **Cell: _____**

City/State/Zip: _____ **(for appointment reminders)**

Email: _____ **Other Phone or Alt Contact:**

Date of Birth: _____ **_____**

Age: _____ **Marital Status: (Circle)**

Height: _____ Weight: _____ **Single Married Divorced Other**

Employer's Name: _____

Emergency Contact: Name/Relationship/Phone Number

_____

Purpose of this appointment: _____

Primary Care Physician and other doctors you have seen for this condition:

_____

Type of treatment: _____Results: _____

When did this condition begin? _____Has it occurred before? YES NO

Are you taking medications (over the counter or prescriptions) YES NO

If YES, please list (many pharmacies will provide you with a list of your medications)

_____

_____

Car Accidents? YES NO Year _____

Other Major Accidents or Falls? _____

Hospitalization or Surgeries: _____

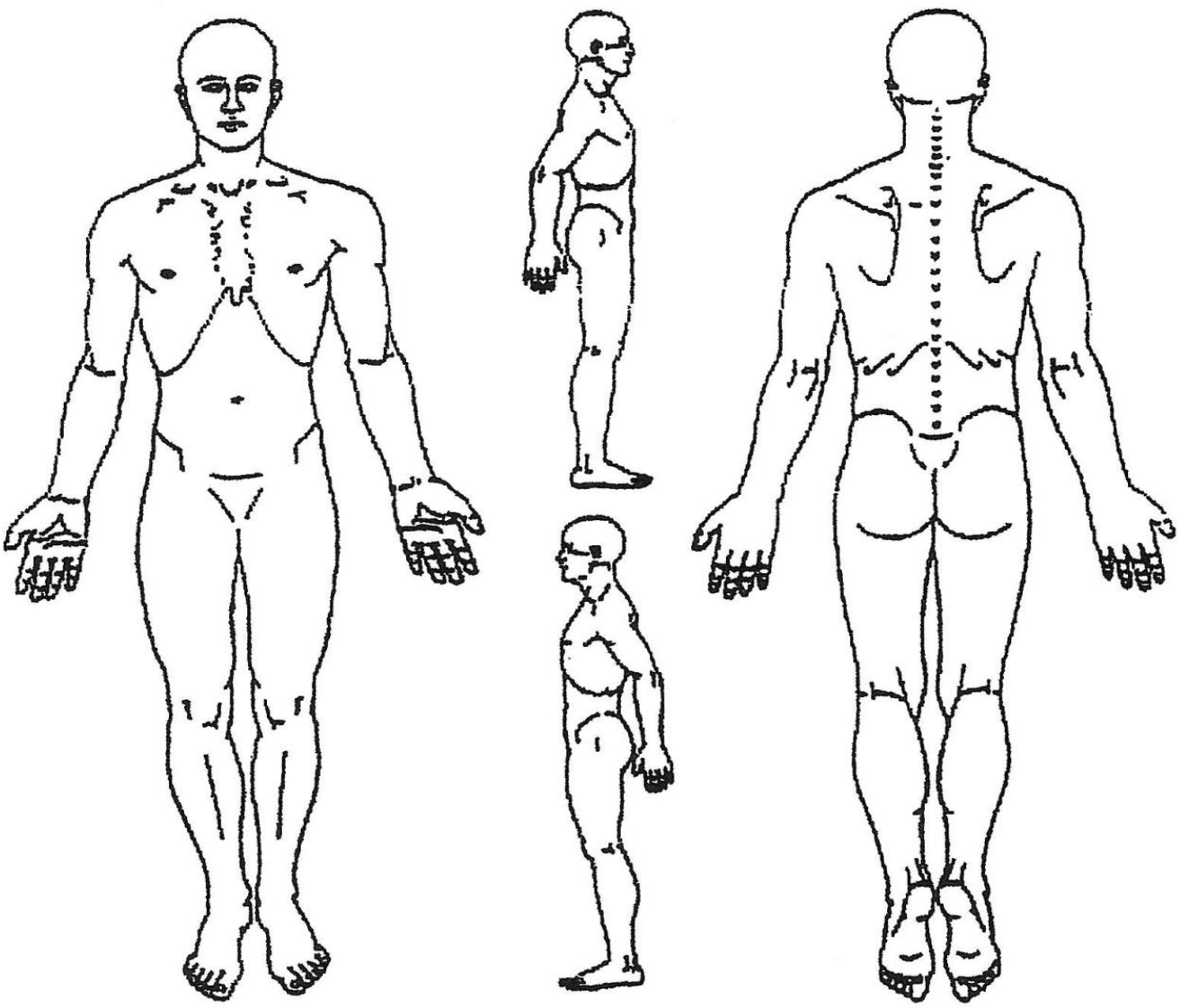
_____

Previous Chiropractic Care: YES NO

If yes, Doctor's Name & Location:_____

Please draw location of your pain or discomfort on the image below.
Use the symbols shown to represent the type(s) of pain:

D = Dull	**S = Stabbing/Cutting**
B = Burning	**T = Tingling (Pins & Needles)**
N = Numb	**C = Cramping**
CP = Chronic Pain (3 Months or longer)	



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right <u>now</u>:

No Pain **Unbearable Pain**

|_____|

Rate your <u>worst</u> pain in the past week:

No Pain **Unbearable Pain**

|_____|

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Since 2001

At what point in your life did you feel your best? _____

What makes your current condition worse/better?_____

Health Goals: Please check all that apply

- ☐ **Nutrition/Diet**
- ☐ **Weight Management**
- ☐ **Pain Relief**
- ☐ **Stress Relief**
- ☐ **Strength Building**
- ☐ **Flexibility**
- ☐ **Balance & Mobility**
- ☐ **Improve Fitness Level**
- ☐ **Wellness or Maintenance**
- ☐ **Injury Rehabilitation**
- ☐ **Injury Prevention**
- ☐ **Coaching & Support**

Other than your chief complaint, what are your top health concerns:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

I am:

- ☐ **Sedentary/Very Inactive**
- ☐ **Somewhat Inactive+0**
- ☐ **Average Activity Level**
- ☐ **Somewhat Active**
- ☐ **Extremely Active**

Hobbies I enjoy...

_____

Recreational Activities...

_____

_____

Do you exercise? YES NO

If so, what kind of exercise do you do? _____

How often? _____

What type of work do you do? _____

Does it require excessive sitting or repetitive movements? YES NO

Do you wear high heels, shoe lifts or orthotics? YES NO

How would you rate your level of stress? (1-10) _____

What are the sources of your stress? _____

_____

Do you have any stiffness, swelling or pain? YES NO

Do you have trouble lying...

face down YES NO

side YES NO

back YES NO

Massage:

Have you had a professional therapeutic massage before? YES NO

What massage technique are you interested in? ☐ Therapeutic/Deep Tissue ☐ Hot Stone

☐ Cupping ☐ Stretching ☐ Trigger Point Therapy ☐ Reflexology ☐ Pre/Post Natal Massage

☐ Lymphatic Drainag ☐ Essential Oils

Other: _____

What pressure do you prefer: ☐ Light ☐ Medium ☐ Deep

Do you have an allergies or sensitivities? (lotions, fragrances, tape) YES NO

_____

Are there any areas on your body you do not wish to be massaged?

_____

Nutrition:

Are you willing to change your diet? YES NO

Do you have any food allergies or foods you avoid? YES NO

Other allergies (environmental/medication)? _____

Do you take supplements? YES NO

If yes, what? _____

What is your blood type? _____

Do you have trouble falling asleep? YES NO Staying Asleep? YES NO

Average hours of sleep per night? _____

Will family and/or friends be supportive of your desire to make lifestyle changes? YES NO

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Disorder
- ☐ Abdominal Aneurysm
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Eczema/Psoriasis
- ☐ Lupus
- ☐ Coma
- ☐ Osteoporosis
- ☐ COVID 19
- ☐ Contagious Conditions
- ☐ HIV Positive

INTAKE PER DAY:

- ☐ Coffee _____
- ☐ Caffeine_____
- ☐ Alcohol _____
- ☐ Tobacco_____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST OR PRESENT:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Weakness
- ☐ Bone Spurs
- ☐ Broken/Dislocated Bones
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Bursitis
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Knee Problems
- ☐ Foot Problems
- ☐ Gout
- ☐ Scoliosis
- ☐ Disc Degeneration
- ☐ Disc Herniation
- ☐ Wrist Problems

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions/Epilepsy/Seizures
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Anxiety

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Problems
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/ Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Issues

C - V - R

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Pacemaker
- ☐ Blood Clots

GENERAL

- ☐ Fatigue
- ☐ Fever
- ☐ Headaches/Migraines
- ☐ Low Temp/Feel Cold
- ☐ Auto Immune Disease
- ☐ Skin Issues
- ☐ Asthma

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose/Sinus Issues

MALE / FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Other:_____

Females Only:

Are you pregnant?

YES NO NOT SURE

Do you have breast Implants:

YES NO

FAMILY HISTORY: Significant family history we should know about: ie. heart disease, cancer

_____

_____

Chiropractic

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medication. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. It is important to understand what to expect from chiropractic health care services.

Analysis

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal adjustment allows nerve transmission through the body and gives the body an opportunity to heal itself.

Diagnosis

Although doctors of chiropractic are experts in chiropractic and diagnosis the VSS, and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms, and should secure other opinions if he/ she has any concern as the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, incoming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in health care regime.

Results

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal and in many cases there is a more gradual, but quite satisfactory response. Rarely, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control of or be helped through conventional medical care. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease as in all healthcare professions, we do not guarantee results.

To the Patient

Attendant Risk and Discomfort Disclosure: There are inherent risks associated with fitness training, strength training or physical treatments which may include, but not limited to, acute muscle and/or joint pain, pulled muscles, brief changes in blood pressure, light headedness, dizziness, or delayed onset muscle soreness (DOMS), minor bruising or discoloration. Training or treatments should be modified or discontinued if any activity causes pain or discomfort.

_____ _____

Date **Signature**

Waiver and Release

Please discuss any questions or problems with the doctor BEFORE signing this statement of policy.
I have read and understand the foregoing.

By Signing Below, I Understand: (please initial each)

_____ Massage is not a replacement for medical care and no diagnosis will be made

_____ Health is a personal responsibility and Health Coaching does not diagnose or treat specific diseases or conditions. I understand a coach is not a licensed professional and it is important to work with my doctor so they can monitor progress while making any lifestyle and/or dietary changes.

_____ That all providers at Island Healing will have access to my chiropractic, massage and fitness records in order to provide the most comprehensive treatment plans. Providers at Island Healing will consult and discuss cases amongst themselves for optimal patient care.

Financial Policy

We are dedicated to providing you with the best possible care.
We want you to completely understand our financial policies.
These policies are designed in an effort to enable us to continue providing quality care in a cost effective manner.

***Insurance Policy*:**
This office is OUT OF POCKET. We do not provide information or bill for personal injury claims or workers comp cases. We do not provide additional information or reports to insurance companies. If you are a Medicare patient, you will not be able to file any claims or receive billing support.

***Payment for Services*:**
Payment for services is required at the time of service unless other arrangements have been made in advance.
We accept cash, check and credit card. There is a $25 fee for all returned checks.

_____ ***No Show*: (Please Initial)**
Patients who do not show up for an appointment or cancel with less than 24 hour notice will be charged the full price of their scheduled service. This fee must be paid prior to a new appointment being scheduled.
I have read this financial policy and understand and agree to the terms and conditions set forth therein.
I agree to be responsible for all fees and costs incurred in connection with collection on my account.

_____ _____

Date Signature (or responsible party)

_____

Printed Name of Patient

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