CHIROPRACTIC | DESIGNED CLINICAL NUTRITION

ALIVE & WELL

Your Health History

Reset Print Email

NAME: _____DATE: _____
ADDRESS: _____
CITY/STATE: _____ZIP CODE: _____
HOME PHONE: _____CELL PHONE: _____
EMAIL ADDRESS: _____
BIRTHDATE: _____OCCUPATION: _____
EMPLOYER: _____
ADDRESS: _____CITY/STATE: _____ZIP: _____
WORK PHONE: _____WHO REFERRED YOU TO US: _____
PAST CHIROPRACTIC CARE? YES/NO, DR.'S NAME/LOCATION: _____
_____
CURRENT MEDICAL CARE? YES/NO, WHY: _____
_____
CURRENT DRUGS/MEDICATION: _____
_____
REASON FOR CONSULTING THIS OFFICE _____
_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR HEALTH/WELLBEING.

☐ I am only concerned about relief of a particular symptom.

☐ I am only concerned about relief of a particular symptom, and preventing its return.

☐ I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

X **SIGNATURE:** _____**DATE:** _____

2 Linden Street Reading, MA 01867 781-942-7121 AWChiro.com info@awchiro.com

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of vertebral subluxation (nerve pressure).

Stress that may be physical, chemical or emotional may cause subluxation.

The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

(Please circle any that apply)

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

For Example,

1) Drugs/medicine/tobacco/alcohol in pregnancy Explain: _____
2) Labor chemically induced _____
3) Forceps/Vacuum Extraction/C-section _____
4) Premature delivery? _____
5) Vaccinations? _____
6) Falls in first year of life _____
7) Any health-related problems _____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

For Example,

1) Any falls or injuries? Explain: _____
2) Allergy/Asthma or Respiratory problems? _____
3) Ear infections? _____
4) Digestive problems? _____
5) Hyperactivity? _____
6) Any other health related problems? _____

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

For Example,

1) Auto Injury? Explain: _____
2) Work Injury? _____
3) Sports Injury? _____
4) Work Stress? _____
5) Family/Home Stress? _____
6) Prescription Drug Use? _____
7) Non-Prescription Drug Use? _____
8) Ever Hospitalized? _____
9) Surgery? _____
10) Major Illness? _____
11) Limited Exercise? _____
12) Poor Nutrition? _____

Any thing else_____
_____

TERMS OF ACCEPTANCE

THESE ARE THE TERMS UNDER WHICH ALL PATIENTS ARE ACCEPTED FOR CARE IN THIS OFFICE:

IT IS CLEARLY UNDERSTOOD THAT THERE IS NO PROMISE OR OFFER OF ANY KIND, ON THE PART OF THE DOCTOR OR THIS OFFICE, TO TREAT ANY SYMPTOM, CONDITION OR DISEASE.

ALTHOUGH I MAY HAVE COME TO THIS OFFICE WITH THE INITIAL EXPECTATION OF RELIEF OF A PARTICULAR SYMPTOM OR CONDITION, IT HAS BEEN CLEARLY EXPLAINED TO ME THAT THE ONLY PURPOSE OF CHIROPRACTIC CARE IS TO REMOVE OR REDUCE NERVE INTERFERENCE CAUSED BY THE PRESENCE OF VERTEBRAL SUBLUXATION.

THIS CORRECTION IS UNDERTAKEN FOR NO OTHER REASON THAN THAT THESE VERTEBRAL SUBLUXATIONS INTERFERE WITH THE CAPACITY OF THE BODY TO FULLY EXPRESS LIFE.

X SIGNATURE: _____DATE: _____

HIPAA (Health Insurance Portability and Accountability Act)

_____ I give permission to Alive & Well Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards and newsletters.

_____ If Alive & Well Chiropractic contacts me by phone, I give them permission to leave a message on my answering machine or voice mail or with another person.

X SIGNATURE: _____DATE: _____

WITNESS: _____DATE: _____