Welcome to our Family

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date_____

Name_____Age _____Date of Birth _____

Home Address_____City _____State_____Zip _____

Home phone (____) _____Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Occupation_____Employer _____

Business Address_____City_____State_____Zip _____

Emergency contact and phone#_____

Marital Status ☐ S ☐ M ☐ D ☐ W ☐ L/W Spouse/Partner _____

Number of Children and ages _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Innate Living Chiropractic can address for you?

1)_____2)_____3)_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C._____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑ years_____

Date of last visit: _____Why did you stop?_____

_____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: _____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the
SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (Check all that apply.)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

_____

_____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, ***state reason and dates:*** _____

_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** _____

_____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? ❑ Good ❑ Fair ❑ Poor

How do you grade your **emotional/mental health**? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall **"quality of life"**? ❑ Good ❑ Fair ❑ Poor

Do you **exercise** regularly? If yes, how often? _____

Do you take **supplements**? If yes, please list:_____

Do you follow a **special dietary regime**? If yes, what? _____

_____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. (Please read pamphlet attached.) The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

FINANCIAL INFORMATION

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

If this is an Auto Accident or a Work-Related injury, please provide us with the following information:

Name of Auto Insurance Co: _____

Have you been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

PLEASE READ AND SIGN BELOW

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give Dr. Melissa Cruz, D.C. permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, necessary x-rays, and any initial care that is determined to be clinically necessary and mutually agreed upon.

NOTICE OF PRIVACY POLICY

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

Signature_____ Today's Date_____

Signature of Parent (for minor):_____Today's Date_____

Informed Consent for Chiropractic Care

When a person seeks the services of a chiropractor and we accept a patient for such care, it is essential for both parties to be working towards the same goals and objectives. It is important that such patient understand both the objective and the method that will be used to attain these goals as recommended by the Doctors at Innate Living Chiropractic. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

We have one goal at Innate Living Chiropractic and that is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine) which interfere with the function of these nerve pathways are called vertebral subluxations. Subluxations are caused by many of the things you do every day and keep your whole body from functioning properly. The removal of the subluxation results in a better expression of health and vitality.

Consequently, the objective of the Doctors at Innate Living Chiropractic is to provide a chiropractic adjustment to correct subluxation thereby restoring normal nerve function. It is not the objective or intention of Innate Living Chiropractic to fix, treat, or attempt to cure any physical, mental, or emotional ailments or to give advice on said ailments. With a proper nerve supply your whole body is better able to reach its full innate potential and to express more life.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

To be completed by the patient or the patient's representative, if necessary:

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name of Representative/Guardian	Signature of Representative/Guardian	Date
_____	_____	_____
Witness Name	Signature of Witness	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