

Welcome to **CHIROPRACTIC GENERATION**

A family chiropractic office

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and lifestyle chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report and your Human Potential Program.

We look forward to a long, healthy relationship with you and your family. Please note our office hours:

Monday	7:30 a.m. – 11:00 a.m. & 2:30 p.m. – 6:00 p.m.
Tuesday	9:30 a.m. – 12:30 p.m.
Wednesday	7:30 a.m. – 11:00 a.m. & 2:30 p.m. – 6:00 p.m.
Thursday	7:30 a.m. – 11:00 a.m. & 2:30 p.m. – 6:00 p.m.
Friday	CLOSED



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 understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An 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: A 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 subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a 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 a 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 objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ Prov _____ Postal _____
 Phone: (H) _____ (W) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Referred By _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____

Number of Children and Ages

Previous Chiropractic Care?

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____

Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
 Major _____
 Pain or Problem started on _____
 Pains are: Sharp Dull Constant Intermittent
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is this condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____
 Have you had X-rays taken in the last six months? Yes No If yes, where? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____
 What medications are you taking? _____
 How Long? _____ Have you had surgery? _____ What? _____ When? _____
 What side effects have you experienced from the drugs and surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your oldest grandparent on record lived to the age of _____. Still living Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

- Feel better quickly
- Have a healthier spine and nervous system
- Live a healthier lifestyle

 Signature

 Date

Office Fee Schedule and Financial Policy

Services

Fees

Initial Consultation & Exam with Computer Scans		\$75.00
Adjustment for:	Adult	\$36.00/visit
	Senior (65 yrs +)	\$32.00/visit
	Student (13-17, full time student)	\$27.00/visit
	Child (12 & under)	\$17.00/visit
Re-exams (including computerized nerve scan)		\$30.00

Financial Policy and Active 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 the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care options. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following documentation options:

- 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 then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that many insurance policies may not reimburse for Critical Transition or Lifestyle Care.
- No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, (name) _____ have read and I understand the above policies. I have initialed the option that applies to me.

Patient signature

Date

Name: _____

Date: _____

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

There are risks and possible risks associated with chiropractic examinations used by doctors of chiropractic and their staff. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.
- b) Patients with skin sensitivity may react adversely to the alcohol swab used to perform the EMG study.

I acknowledge that if I choose not to consent to all and/or part of the examination I will have ample opportunity to discuss with the doctor further options. I also understand that without a thorough examination, no treatment will be provided to me. I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic examination in general, options and recommendations in particular for my condition.

Patient Signature or Legal Guardian

Witness of Signature

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of manual therapy techniques. Although, uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

Patient Signature or Legal Guardian

Witness of Signature