AUTHENTIC LIFE
FUNCTIONAL MEDICINE | GENETICS
NUTRITION | CHIROPRACTIC

Your Facts

C1

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Date of Birth: ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

Employer: _____ **Work #:** _____ **Ext:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

Are you currently taking any medications or supplements? (*Please include regularly used over the counter medications*).....

Medication Name	Dosage and Frequency

Supplement Name	Dosage and Frequency

Do you have any medication, food, or environment allergies?

Medication, Food or Location	Reaction

Please list 3 major health goals in order of priority:

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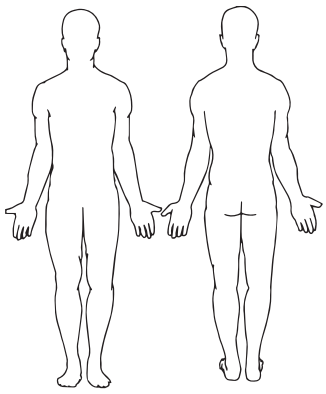
Your Consultation

C2

Name: _____ **Date of Birth:** _____ **Date:** _____

Pain Location



Front **Back**

Present Condition

List conditions in order of concern and mark location of pain.

(minor) **Pain Scale** *(extreme)*
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1. _____
2. _____
3. _____
4. _____
5. _____

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse

Explain: _____

What makes pain better? _____

Worse? _____

Difficult activities: _____

Who Have You Seen:

Who have you seen for your symptoms, and when? ***Date***

Chiropractor: _____

_____

Medical Doctor: _____

_____

Physical Therapist: _____

_____

Other: _____

_____

Have You Had:

Blood analysis	☐ Yes	☐ No	_____ When
Blood pressure check	☐ Yes	☐ No	_____ When
Bone density	☐ Yes	☐ No	_____ When
Eye exam	☐ Yes	☐ No	_____ When
Feelings of hopelessness	☐ Yes	☐ No	_____ When
Feelings of depression	☐ Yes	☐ No	_____ When
Feelings of anxiety	☐ Yes	☐ No	_____ When
Feelings of panic	☐ Yes	☐ No	_____ When
MRI	☐ Yes	☐ No	_____ When
Spinal x-ray	☐ Yes	☐ No	_____ When

Current Symptoms

1

- ☐ Knee Pain
- ☐ Leg Cramps
- ☐ Numbness in Toes
- ☐ Tingling in Legs
- ☐ Weakness In Legs

2

- ☐ Urinating Issues
- ☐ Lower Back Pain
- ☐ Ringing in Ears

3

- ☐ Bladder Infections
- ☐ Belching
- ☐ Constipation

3

- ☐ Indigestion
- ☐ Vomiting

4

- ☐ Arm Pain
- ☐ Circulatory Problems
- ☐ Hands Cold
- ☐ Mid-Back Pain
- ☐ Numbness in Fingers
- ☐ Shortness of Breath
- ☐ Shoulder Pain
- ☐ Tingling in Arms

5

- ☐ Back Pain
- ☐ Dizziness
- ☐ Hair Loss
- ☐ Hay fever
- ☐ Hives
- ☐ Loss of Balance/Dizzy
- ☐ Neck Pain/Stiffness
- ☐ Nervousness

6

- ☐ Bruise Easily
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Frequent Colds
- ☐ Hemorrhoids

6

- ☐ Loss of Smell/Taste
- ☐ Muscle Spasms
- ☐ Sight Sensitivity
- ☐ Sinus Problems

7

- ☐ Cold/Hot Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Joints Swelling/Pain
- ☐ Sleep Problems
- ☐ Stress
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

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Your History

C3

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis - *Type*_____	☐	☐	☐	☐	☐
Birth Trauma	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐
Cancer -*Type*_____	☐	☐	☐	☐	☐
Cholesterol - High	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addictions	☐	☐	☐	☐	☐
Eye Condition	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder	☐	☐	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	☐	☐
Glasses/contacts	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
HIV/AIDS	☐	☐	☐	☐	☐
Immune System - Weak	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐
Scarlet Fever	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Patterns

Mark those that apply and amount if applicable.

Example: Lift Weights **3 X wk**
Bowel movements _____
Drive a stick shift _____
Eat out frequently _____
Enjoy work _____
Exercise _____
Healthy relationships _____
Lift weights _____
Nicotine _____
Phone work excessive _____
Skip meals _____
Sleep comfortably _____
Sleep on stomach _____
Two story residence _____
Wear seat belts _____
Work hours per week _____

Rate Your Activities

Rate the degree of pain related to performing these activities.

	None	Some	Always
Climbing Stairs	☐	☐	☐
Computer work	☐	☐	☐
Dressing	☐	☐	☐
Driving/riding in cars	☐	☐	☐
Exercise	☐	☐	☐
Getting in/out of cars	☐	☐	☐
Getting out of bed	☐	☐	☐
Using the restroom	☐	☐	☐
Housework	☐	☐	☐
Running	☐	☐	☐
Sexual Intercourse	☐	☐	☐
Sitting	☐	☐	☐
Taking care of child	☐	☐	☐
Walking	☐	☐	☐
Yard work	☐	☐	☐

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Our Financial Policy

FP1

Name: _____ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

PATIENTS WITHOUT INSURANCE OR SELF PAY: If you are not insured OR not insured by a plan we participate with, **payment is expected in FULL at each visit.** If you are seeing our doctors on an "out of network" basis you may request a "Superbill" so that you may submit it to your insurance company for out-of-network reimbursement.

PATIENTS WITH INSURANCE: Deductibles, co-insurance and all co-payments, along with any services not covered by insurance are expected at the time of service. Unless other arrangement is made to delay this payment until the insurance company pays. Then the client will have 15 days to pay the balance due. If payment is not made in 15 days, the credit card listed on the credit card authorization that is listed at the end of this policy will be charged. **All co-payments and deductibles must be paid at the time of service.**

PATIENT BILLING & BALANCES DUE: Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. In the event that you do not pay your co-payment or deductible payment at the time of service OR your insurance carrier assigns any additional patient responsibility amounts after the claim is processed, **we will charge the credit card on file for such patient responsibility, co-payment or deductible amount to the following extent:**

1. **If the balance due is less than $100 your card will be charged automatically.**
2. **If the balance due is greater than $100, we will contact you 72 hours prior to your card being charged.** Should you decide to use an alternate method of payment OR set up a payment plan, please **alert our office within 72 hours of our contact,** and our contact shall include a voice message from the affiliate practioners that operate within Your Wellness Connection to you if we are unable to reach you.
3. Payment plans ARE available upon request.
4. **A $10 late fee per month may** be charged to your account if your balance is unpaid 90 days after your last visit until balance is paid in full.
5. If we do not receive payment in full for the balance due, or you have not set up an automatic payment plan **after 6 months of an unpaid balance your account may be forwarded to collections,** and you hereby agree that if the affiliate practioners that operate within Your Wellness Connection place your account with an agency or attorney for collection, you will pay the affiliate practioners that operate within Your Wellness Connection all of its costs and expenses in collecting monies owed by you to the extent allowed by applicable law.
6. If your credit/debit card on file expires or otherwise becomes uncollectible, the affiliate practioners that operate within Your Wellness Connection will expect you to promptly provide a new credit or debit card.
7. **A $25 returned check fee will** apply towards your account for checks returned for insufficient funds.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

_____ **Today's Date:** ____/____/____

Signature of Patient/Parent/Guardian

_____

Printed name of Patient/Parent/Guardian

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Our Financial Policy *(continued...)*

FP2

Name: _____ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

ASSIGNMENT OF BENEFITS: I, the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to the affiliate practioners that operate within Your Wellness Connection all insurance benefits, payable to me for services rendered, I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services, I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I consent to the use or disclosure of my medical information by the affiliate practioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the affiliate practioners that operate within Your Wellness Connection. I understand that diagnosis or treatment of me by the affiliate practioners that operate within Your Wellness Connection may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. The affiliate practioners that operate within Your Wellness Connection are not required to agree to the restrictions that I may request. However, if the affiliate practioners that operate within Your Wellness Connection agree to a restriction that I request, the restriction is binding on the affiliate practioners that operate within Your Wellness Connection. I have the right to revoke this consent, in writing, at any time, except to the extent the affiliate practioners that operate within Your Wellness Connection have taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review the affiliate practioners that operate within Your Wellness Connection's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of the affiliate practioners that operate within Your Wellness Connection. This Notice of Privacy Practices also describes my rights and the duties of the affiliate practioners that operate within Your Wellness Connection with respect to my medical information. The affiliate practioners that operate within Your Wellness Connection reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I hereby authorize the front desk and the affiliate practioners that operate within Your Wellness Connection to charge my credit, debit, or HSA card on file for the full amount owed by me for all services and/or treatment rendered by the affiliate practioners that operate within Your Wellness Connection in accordance with the terms above. Effective until revoked by you in writing.

_____ **Today's Date:** ____/____/____

Signature of Patient/Parent/Guardian

_____

Printed name of Patient/Parent/Guardian

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Chiropractic Informed Consent

IC1

Name: _____ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Today's treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, active or passive stretching, instrument-assistant soft tissue manipulation (IASTM), massage techniques (including but not limited to effleurage, petrissage, compression, and tapotement) and the application of kinesiology tape. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, disc injury, reddening of the skin and/or development of petechiae (small broken capillaries in the skin's surface), bruising, itching and/or blistering of the skin, muscle, ligament, or joint injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability to ensure the maximum improvements. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported.

Adjustment – Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential Current Therapy – Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental Traction Therapy – This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Active or Passive Stretching – Areas of the body taken through active or passive range of motions to encourage stretching and lengthening of the muscles and increased circulation.

Instrument-Assisted Soft Tissue Release (IASTM) – A treatment to break up adhesions or scar tissue detected by the stainless steel instrument in the area of complaint to increase range of motion, decrease pain, improve circulation, encourage healing, and prevent the formation of the development of scar tissue.

Massage Techniques – Including but not limited to effleurage, petrissage, compression, and tapotement techniques to encourage muscle relaxation, stretching and lengthening of the muscles and increase circulation.

Kinesiology Taping – The application of elastic adhesive tape to the area of complaint to help eliminate pain, aid in proper muscle and joint function, provide support and neuromuscular re-education.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatments.

By signing this form you consent to disclose any and all relevant medical health conditions (i.e. cardiovascular, neurological, skin, muscle or joint conditions) that could be a contraindication to treatment.

DO NOT RECEIVE TREATMENT IF YOU HAVE ANY OF THE FOLLOWING: AN INFECTIOUS OR CONTAGIOUS SKIN DISEASE, OR INFLAMMATORY CONDITION AFFECTED BY INCREASED BLOOD CIRCULATION.

_____ **Today's Date:** ____/____/____

Signature of Patient/Parent/Guardian

_____

Printed name of Patient/Parent/Guardian