The Woodrail Center
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Our focus is on assisting people to function optimally in order for them to become more self-aware, stronger and healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time contributing to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

PATIENT DEMOGRAPHICS DATE:

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Cell Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Other Do you have Insurance: ❑ Yes ❑ No

Employer: _____Occupation: _____ Work Phone: _____

Would your workplace or organization benefit from complimentary wellness workshops? ❑ Yes ❑ No

Spouse's Name _____ Spouse's Employer _____

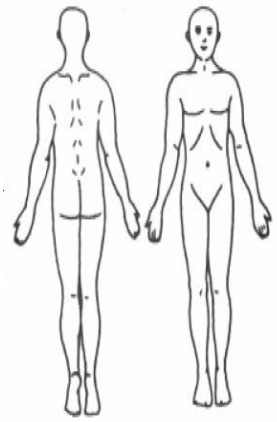
Number of children and Ages: _____

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

HISTORY of COMPLAINT

List your concerns below from most pertinent to least. On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your complaints by c*ircling the number*: On the body diagram, mark areas with the following **letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



1) _____ 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

2) _____ 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

3) _____ 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____

☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week

What relieves your symptoms? _____

What makes them feel worse? _____

List any activities your symptoms have kept you from doing either partially or completely that you would like to do more of. _____

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If Yes, when was the last episode? _____

Have you tried other forms of treatments? ☐ No ☐ Yes If yes, what type of treatment: _____

Female patients only: Are you currently pregnant? ☐ No ☐ Yes

Is there anything else that you would like to tell us, to help us understand you and your health concerns?

_____

_____

What are your health objectives? ☐ Temporary relief only ☐ Correction and Prevention ☐ Health Development

List any medications you currently take_____

In addition to your main reason for your visit today, what additional health goals do you have for your future?

_____

_____

NUTRITIONAL TESTING AND COUNSELING

Are you taking any Omega-3 supplements?	☐ Yes ☐ No
Are you taking any Vitamin D supplements?	☐ Yes ☐ No
Are you taking any magnesium supplements?	☐ Yes ☐ No
Are you taking any Probiotics?	☐ Yes ☐ No
Would you be interested in food sensitivity testing?	☐ Yes ☐ No

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes If yes whom:_____
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: If yes please explain: _____

_____

PAST HISTORY

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate:

☐ Tumors or Cancer ☐ Rheumatoid Arthritis ☐ Fracture/Broken bone ☐ Heart Attack ☐ Diabetes
☐ Stroke/TIA ☐ Osteo Arthritis ☐ Dislocations ☐ Pacemaker ☐ Joint Replacement
☐ Other serious condition(s) or surgeries: _____

List any accidents, falls, or traumas you have experienced:_____

_____

SOCIAL HISTORY

1. Smoking:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never
2. Alcohol Consumption:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never
3. Recreational Drug use:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never

MEDICAL DOCTOR

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit:_____
May we communicate with your family doctor regarding your care if necessary? ☐ Yes ☐ No

CONSENT TO TREAT A MINOR- only if services are for minor

I, _____, being the parent or legal guardian of _____ have read and
(PARENT/GUARDIAN NAME) (CHILD'S NAME)
Fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Guardian Signature: _____ Date:_____

INFORMED CONSENT AND HIPPA TO CHIROPRACTIC CARE

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective. Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental and social wellbeing, not merely the absence of symptoms.

I understand that my care at Achieve Balance Chiropractic will be focuses on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. 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. Please discuss care alternatives with Dr. Phelps.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At Achieve Balance Chiropractic, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

HIPPA

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability. Initials: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

I, _____ have ready and fully understand the above statements.
(Print Name)
I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Arminta Phelps.

_____

(SIGNATURE) (DATE) (WITNESS)

(Information released from: The National Center for Health Statistics, USA, 1993 and a Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-Inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct 1995)