Dynamic Life CHIROPRACTIC

Time_____ RM____
_____ T 1 2 3

Name_____Date of Birth_____/_____/_____Age_____ Male / Female

Address_____City_____State_____Zip_____

Phone: Home_____Cell_____Cell Phone Provider_____

Social Security Number_____Email Address_____

Occupation_____Employer's Name_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____Names, Ages & Gender_____

_____

Who may we thank for referring you?_____ Office Only _____

LIST YOUR HEALTH CONCERNS BELOW:

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER HEALTH CARE PROVIDERS FOR THESE CONDITIONS? YES / NO

Chiropractor?_____Medical Doctor?_____Other_____

Name and Date of Providers_____

Result of Care_____

CIRCLE ALL PROBLEMS YOU CURRENTLY HAVE or HAD:

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	DISC PROBLEM
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	INFERTILITY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	LUPUS
EAR INFECTIONS	ULCERS	SCIATICA	FIBROMYALGIA	OTHER_____
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	GASTRIC REFLUX	_____
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	_____
NECK PAIN	LOW BACK PAIN	ARM PAIN	MENSTRUAL DISORDER	_____
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	_____
ANXIETY	STOMACH DISORDERS	LEG PAIN	NERVOUSNESS	_____
CHRONIC SINUS	BLADDER PROBLEMS	KNEE PAIN	EPILEPSY	_____

CIRCLE ANY CONDITION YOU HAVE NOW and/or HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

List ALL surgical operations and years_____

_____

List all supplements, over-the-counter & prescription medications you are taking_____

_____

_____

When was your last auto accident?_____

Have you had previous chiropractic care? YES / NO

If you have, Dr. & date_____

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO

If yes, please describe_____

Other trauma_____

_____

SOCIAL HISTORY

1. Tobacco: ___Cigars ____Pipe ___Cigarettes ___E-Cigarettes ___Chew
   How often? ___Daily ____Weekends ___Socially ___Occasionally ___Never
2. Exercise: How often? ____Daily ____Several Days per Week ____Weekends ____Occasionally ___Never
3. How does your present problem affect the following: *Hobbies* | *Recreational Activities* | *Exercise*

   _____
4. What daily activities are being changed or restricted by your current health problems:

   _____

   _____
5. What could you do or would like to do if you were not restricted by your current health problems:

   _____

   _____

Pain and Symptom Rating Scale

Please circle the number that best describes the question asked. If there is more than one condition, please answer each question for each individual complaint and indicate the score of each complaint.

EX: No pain _____Worst possible

0 1 2 3 4 5 6 7 8 9 10 Pain

Headache Hip Pain

1. How would you rate the symptom/pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is the typical or AVERAGE of the symptom/pain? (How bad is the symptom/pain throughout most of a day?)

0 1 2 3 4 5 6 7 8 9 10

3. What is the symptom/pain level at its BEST? (How close to 0 does the symptom/pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the symptoms/pain at its best? _____%

4. What is the symptom/pain level at its WORST? (How close to 10 does the symptom/pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the pain at its worst?_____%

***Please Mark** the areas on the Diagram with the following **letters** to describe your symptoms:

R=Radiating **B=**Burning **D=**Dull **A=**Aching **N=**Numbness **S=**Sharp/Stabbing **T=**Tingling

What relieves your symptoms?_____

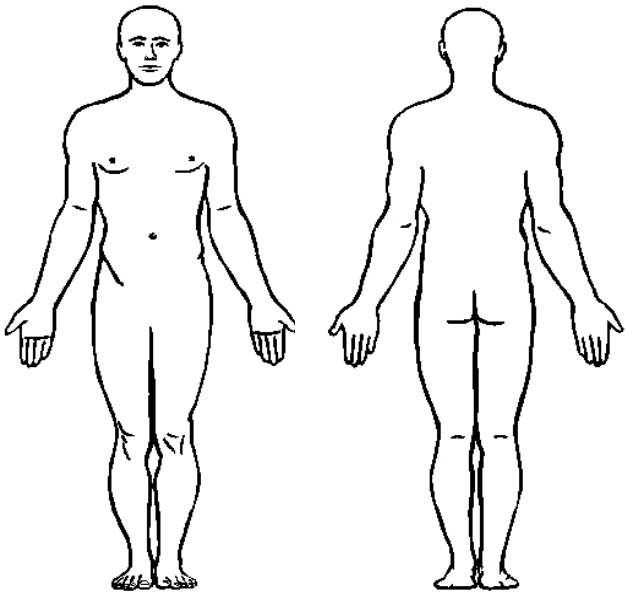
_____

_____

What makes them feel worse?_____

_____

_____



Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Stand Up from Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lift Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read/Concentrate	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Get Dressed	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shave	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Fall Asleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep Through the Night	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit for a Period of Time	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Stand for a Period of Time	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walk	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Wash/Bath	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweep/Vacuum	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Wash Dishes	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Clean Laundry	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Take out Garbage	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Operate Vehicle	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercise	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Recreation	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

****IF ANY ACTIVITY IS <u>NOT PAINFUL BUT HAS BECOME DIFFICULT</u> FOR YOU TO PERFORM or YOU HAVE HAD TO MODIFY HOW YOU PERFORM IT, PLEASE <u>CIRCLE</u> or <u>WRITE-IN</u> THAT ACTIVITY.**

Example: "Standing up from sitting is not painful, however I now have to use support, so I can stand."

Stand Up from Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Family Health History

Please make indications with an 'X'. This form is vital to the doctor. By providing current and past family health history information, you are ensuring that the doctor has all the information necessary to provide the most accurate and best care possible.

CONDITION	SPOUSE	SON	DAUGHTER	FATHER	MOTHER
Arm, Wrist, or Hand Pain/Numbness					
Arthritis					
Anxiety					
Asthma					
ADD/ADHD					
Allergies or Sensitivities					
Back Pain					
Bed Wetting					
Cancer					
Carpal Tunnel					
Depression or PTSD					
Diabetes					
Digestive or Stomach Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headache or Migraines					
Heartburn or Indigestion					
High Blood Pressure					
Hip Pain					
Leg Pain or Sciatica					
Menstrual Disorders					
Neck Pain					
Scoliosis					
Seizures					
Shoulder Pain					
Sinus Trouble					

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays onto a disc is $15.00, paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day.
PLEASE NOTE: X-rays are utilized in this office to help locate and analyze vertebral subluxations and joint dysfunction.
While these images do add to the safety of your care, these x-rays are not used to investigate for medical pathology. The doctor(s) of Dynamic Life Chiropractic do not diagnose or treat medical conditions; however, they are trained to recognize, abnormalities and signs of contraindication to adjusting and if they are found, we will bring it to your attention, so you can seek proper medical advice.
By signing below, you are agreeing to the above terms and conditions and any risk involved.

_____ _____/_____/_____ _____
Signature Date Age

FEMALE PRACTICE MEMBER ONLY: I ensure that to the best of my knowledge I am not pregnant.

_____ _____/_____/_____
Signature Date

Sex: MALE / FEMALE

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

☐ Lat Cervical ☐ Flex/Ext

CM	kVp	Time	mAs
☐ 10-11	☐ 78	☐ 1/24	12.5
☐ 12-13		☐ 1/20	15
☐ 14-15		☐ 1/15	20
☐ 16-17		☐ 1/10	30
		☐ 2/15	40

mA 300 Size 8x10

☐ APOM

CM	kVp	Time	mAs
☐ 14-15	☐ 70	☐ 1/10	20
☐ 16-17		☐ 2/15	30
☐ 18-19		☐ 3/20	40
☐ 20-21		☐ 2/10	50
☐ 22-23			

mA 300 Size 8x10

Notes:

_____
_____
_____
_____
_____
_____

☐ Lower Cervical

CM	kVp	Time	mAs
☐ 14-15	☐ 70	☐ 1/10	20
☐ 16-17		☐ 2/15	30
☐ 18-19		☐ 3/20	40
☐ 20-21		☐ 2/10	50
☐ 22-23			

mA 300 Size 8x10

☐ BP

CM	kVp	Time	mAs
☐ 14-15	☐ 70	☐ 1/10	20
☐ 16-17		☐ 2/15	30
☐ 18-19		☐ 3/20	40
☐ 20-21		☐ 2/10	50
☐ 22-23			

mA 300 Size 8x10

☐ Other

Views _____
CM _____
kVp _____
mAs _____
MA _____
Size _____

X-Ray Tech Initials

_____

☐ Lateral Thoracic

CM	kVp	Time	mAs
☐ 22-23	☐ 80	☐ 1/15	20
☐ 24-25		☐ 1/10	30
☐ 26-27		☐ 2/15	40
☐ 28-29		☐ 2/10	50
☐ 30-31		☐ 1/4	75
☐ 32-33		☐ 3/10	90
☐ 34-35		☐ 2/5	120
☐ 36-37		☐ 1/2	150

mA 300 Size 14x17

☐ Lateral Lumbar

CM	kVp	Time	mAs
☐ 26-27	☐ 88	☐ 2/10	30
☐ 28-29	☐ 90	☐ 1/4	40
☐ 30-31	☐ 92	☐ 3/10	50
☐ 32-33	☐ 94	☐ 2/5	70
☐ 34-35	☐ 96	☐ 1/2	90
☐ 36-37		☐ 3/5	120
☐ 38-39		☐ 4/5	160
☐ 40-41		☐ 1	200
☐ 42-43		☐ 1.5	
		☐ 2	

mA 300 Size 14x17

☐ A-P Thoracic

CM	kVp	Time	mAs
☐ 16-17	☐ 75	☐ 1/20	17
☐ 18-19		☐ 1/15	22
☐ 20-21		☐ 1/10	30
☐ 22-23		☐ 2/15	40
☐ 24-25		☐ 2/10	50
☐ 26-27		☐ 1/4	75
☐ 28-29		☐ 3/10	90
☐ 30-31		☐ 2/5	120

mA 300 Size 14x17

☐ Lateral Lumbar

CM	kVp	Time	mAs
☐ 20-21	☐ 76	☐ 1/15	40
☐ 22-23	☐ 78	☐ 0/10	50
☐ 24-25	☐ 80	☐ 2/15	75
☐ 26-27		☐ 2/10	90
☐ 28-29		☐ 1/4	120
☐ 30-31		☐ 3/10	150
☐ 32-33		☐ 2/5	120
☐ 34-35		☐ 1/2	170
☐ 36-37		☐ 3/5	210
☐ 38-39		☐ 4/5	
☐ 40-41		☐ 1	
☐ 42-43		☐ 1.5	
		☐ 2	

mA 300 Size 14x17

Billing Policies and Fees

- **Consultation -** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member) -** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, orthopedic evaluations, leg check. $60-150
- **Chiropractic Adjustment -** The realignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $0-60
- **X-rays -** Specific x-ray views taken of your spine and/or extremities to determine a misalignment/subluxation of your vertebrae and extremity joints. These can also be used to indicate progress after period of care. $50-350

Terms of Acceptance

In order to provide for the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. ***Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.***

B. ***Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of subluxation(s). Subluxations are deviations from normal spinal and extremity structures and configurations that interfere with normal nerve processes which results in less than optimum body function.***

C. ***The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine and extremities with the specific intent of restoring proper motion and nervous system tone. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.***

D. ***A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The purpose of this process is to identify any spinal, joint, and nervous system health problems and determine your exact chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.***

E. ***Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.***

F. ***Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.***

G. ***We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.***

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____/_____/_____

Signature Date

Medical Information Release Form

Practice Member Name_____Date of Birth_____/_____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Notice of Privacy Practices Acknowledgement

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

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____/_____/_____

Signature Date

Informed Consent for Chiropractic Care

When a practice member seeks chiropractic health care. and we accept a practice member for such care, it is essential for both to be working for the same objective. It is important that each understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a practice member, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Other joints in the arms, legs, and jaw are also subject to these same changes. While other healing professions can provide exceptional supplemental and rehabilitative services, there is no alternative to the training a chiropractor receives in the specific detection and correction of subluxation. Choosing to not have these corrected may lead to progressive degeneration and dysfunction, worsening symptoms, increased pain, and increased need for medical interventions.

Subluxations are corrected by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by highly-specific manual adjustments of the spine and extremities. Adjustments are done by hand or instrument in this office.

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.

As with anything in life, there is always some risk involved. Due to the nature of physics and the transfer of a force and the dynamic nature of the human body, there is a low risk of trauma-like injury such bruising, soreness, sprain/strain, fracture, dislocation. Sometimes, in the healing process, symptoms can worsen before they begin to improve. Dynamic Life Chiropractic team members are trained to recognize underlying conditions that may contribute to these events. Dr. Gabriel Waterman has received specific technique training to greatly decrease the risk of these events occurring. Your health and well-being is our is greatest priority.

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 consent to chiropractic care on this basis.

_____	_____	_____/_____/_____
Print Name	Signature	Date

IF THIS HEALTH INTAKE IS FOR A MINOR, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A MINOR

MINOR'S NAME_____

I AUTHORIZE DR. GABRIEL WATERMAN AND THE DYNAMIC LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY DYNAMIC LIFE CHIROPRACTIC.

_____	_____	_____/_____/_____
PARENT/GUARDIAN NAME	SIGNATURE	DATE

_____
RELATIONSHIP TO MINOR