Time_____ RM____
_____ T 1 2 3

Name_____Date of Birth_____/_____/_____Age_____ Male / Female

Address_____City_____State_____Zip_____

Full SSN_____Phone #_____

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 DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor?_____Medical Doctor?_____Other_____

Name and Date of Providers_____

Result of Care_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

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 over the counter & prescription medications you are on_____

_____

_____

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

If yes, please describe_____

Other major traumas_____

Have you had previous chiropractic care? YES / NO

If you have, Dr. & date_____

Social History

1. **Tobacco:** ___Cigars ____Pipe ___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 restricted by your current health problems:**

   _____

   _____
5. **What could you do or would like to do if you weren't restricted by your current health problems:**

   _____

***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?_____

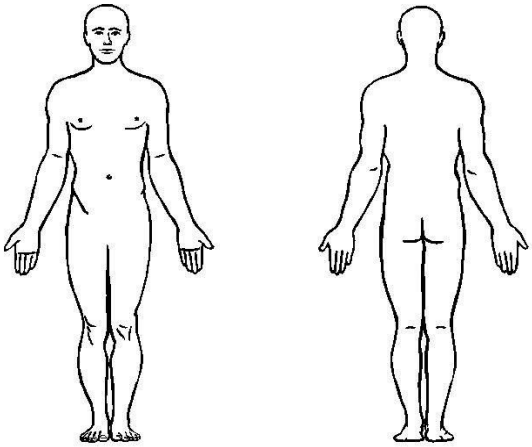
_____

_____

What makes them feel worse?_____

_____

_____



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 ON A DISC IS $15.00. THIS FEE MUST BE 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. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF DYNAMIC LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____/_____/_____ _____
Signature Date Age

FEMALE PRACTICE MEMBER ONLY: I have informed the x-ray tech whether I am or am not pregnant at the time x-rays are taken at Dynamic Life Chiropractic.

_____ _____/_____/_____
Signature Date

Insurance Policies and Fees

- **Consultation -** includes practice member history.
- **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. $75
- **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. $60
- **X-rays -** Specific x-ray views of your spine taken and analyzed to determine the misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $190 - Upper Cervical series, $50 - each other region

Authorization/Assignment of Insurance Benefits Release

I authorize and request payment of insurance benefits directly to Dynamic Life Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. I understand that all professional services rendered are charged to the practice member and that it is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by the assigned and that Dynamic Life Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

_____ _____/_____/_____
Signature Date

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 spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

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 with the specific intent of re-positioning misaligned spinal segments. 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 goal of this process is to identify any spinal health problems and 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

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

Medical Information Release Form

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_____

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

_____ _____/_____/_____

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 practice member 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. Choosing to not have these corrected may lead to progressive degeneration and dysfunction, worsening symptoms, increased pain, 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 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 as 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 is our 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 accept chiropractic care on this basis.

_____ _____ _____/_____/_____

Print Name Signature Date

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

Written Consent for a Child

CHILD'S NAME_____

I AUTHORIZE DR. GABRIEL WATERMAN AND ANY 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/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY DYNAMIC LIFE CHIROPRACTIC.

_____ _____ _____/_____/_____

Guardian Name Guardian Signature Date

_____

Relationship to Minor / Child

Auto Injury Questionnaire

Practice Member Name_____	Make/Model of your car_____
Auto Insurance Company_____	Make/Model of other involved vehicle _____
Name on policy (if other than yourself)_____	Amount of damage to your car $_____

Attorney Information

Attorney's Name_____Firm_____

Phone_(_____)_____

Address_____City_____State_____Zip_____

Nature of Accident

1. Date of accident_____ Time of Day_____
2. Were you in: *Driver seat* *Passenger seat* *Backseat Driver Side* *Backseat Passenger Side* *Middle seat*
3. Did the airbags deploy? *Yes / No*
4. Were you wearing a seatbelt? *Yes / No*
5. Were you struck from: *Behind* *Front* *Driver Side* *Passenger Side*
6. Were you aware of the impending accident or were you taken by surprise? *Aware / Surprised*
7. Speed of your vehicle?_____mph Other vehicle_____mph
8. In your own words, please describe the accident: _____

   _____

   _____

   _____
9. Were you knocked unconscious? *Yes / No*
10. Did you have any physical complaints/injuries/problems BEFORE the accident? *Yes / No*
11. Please describe what you felt:
    a. During the accident_____
    b. Immediately after the accident_____
    c. Later that day_____
    d. The next day_____
12. Were you taken to receive medical evaluation or care after the accident?_____

    List treatment/procedures you received_____
13. What other Dr's have treated you for injury since the accident_____
14. Since the accident, your symptoms are: *Improving* *Getting Worse* *Same*
15. Was an accident report filed? *Yes / No*

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness with regard to the various activities listed below. Use the following 0 to 4 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty:

0 ="I can do it without any difficulty" 1 ="I can do it without much difficulty, despite some pain" 2 ="I can manage to do it by myself, despite marked pain"
3 ="I manage to do it, despite the pain, but only if I have help" 4 ="I cannot do it at all because of the pain" *Only in areas affected by accident.*

_____**Difficulties with Self Care and Personal Hygiene Activities**

Bathing…….....	_____	Drying hair…….....	_____	Brushing teeth……..….	_____	Putting on shoes.....	_____
Preparing meals……..	_____	Showering…….….	_____	Combing hair…….....	_____	Making bed…….....	_____
Tying shoes……	_____	Eating……	_____	Doing Laundry……..	_____	Washing hair……	_____
Washing face……..	_____	Putting on pants…….	_____	Cleaning dishes……..	_____	Going to toilet…..…	_____

_____**Difficulties with Physical Activities**

Standing…….....	_____	Walking……..….....	_____	Kneeling……..….....	_____	Reaching…….....	_____
Twisting left …….....	_____	Twisting right…….....	_____	Stooping…….....	_____	Leaning back…….....	_____
Leaning forward……....	_____	Leaning left…….....	_____	Leaning right…….....	_____	Bending left….....	_____
Bending right…….....	_____	Bending back……..….	_____	Bending forward…….....	_____	Reclining…….....	_____
Squatting…….....	_____	Sitting for long periods.	_____	Standing for long periods.	_____	Walking for long periods	_____
Kneeling for long periods.....	_____						

_____**Difficulties with Functional Activities**

Carrying small objects……..…...	_____	Carrying large objects…….....	_____	Carrying briefcase…….....	_____
Carrying large purse……..…...	_____	Lifting weights off floor…….....	_____	Lifting weights off table…….....	_____
Climbing stairs…….....	_____	Climbing inclines…….....	_____	Pushing things while seated.....	_____
Pushing things while standing….....	_____	Pulling things while seated……..	_____	Pulling things while seated……..	_____
Exercising upper body…….....	_____	Exercising lower body…….....	_____	Exercising arms…….....	_____

_____**Difficulties with Social and Recreational Activities**

Bowling….....	_____	Fishing.....	_____	Jogging…….	_____	Biking.....	_____	Competitive sports….	_____
Dating…….	_____	Golfing…….	_____	Swimming…	_____	Skiing……..…	_____	Roller skating…….	_____
Hobbies……..	_____	Dining out…..	_____	Dancing……	_____	Boating.....	_____	Other (describe below)	_____

_____**Difficulties with Traveling**

Driving in a motor vehicle……..……..……..	_____	Driving for long periods of time……..……..…..	_____
Riding as a passenger……..……..……	_____	Riding as a passenger on an airplane……..……..…...	_____
Riding as a passenger on a train……..…….	_____	Riding as a passenger for long periods……..…….	_____

Use the following 0 to 4 scale to describe the difficulties below:
0 = "This area is not affected by my condition" 1 = "This area is slightly affected by my condition" 2 = "My condition moderately restricts my ability in the area"
3 = "My condition seriously limits my ability in this area" 4 = "My condition prevents me from using the ability"

_____**Difficulties with Different Forms of Communication**

Concentrating…	_____	Hearing…….	_____	Reading…	_____	Using a keyboard……..……..……..	_____
Writing……...	_____	Listening……	_____	Speaking……..	_____		

_____**Difficulties with Senses**

Seeing……..	_____	Hearing…….	_____	Sense of touch…..	_____	Tasting…..	_____	Smelling……..…...	_____

_____**Difficulties with Hand Functions**

Grasping..	_____	Holding..	_____	Pinching...	_____	Percussive movements...	_____	Sensory discrimination....	_____

_____**Difficulties with Sleep and Sexual Function**

Able to have normal, restful night's sleep…….....	_____	Able to participate in desired sexual activity…..…….	_____

Please write in below any additional information regarding your Activities of Daily Living (that was not covered above)

_____

_____

_____/ 368 _ **Score** **Eval Date** _____

PI Practice Member-Provider Contract and Promissory Note

Enter This Day between Dr. Gabriel Waterman (hereafter 'Provider') and _____ (hereafter 'Practice Member'). Provider hereby agrees to establish an active account for the Practice Member and to provide essential services for the purposes of benefiting and improving Practice Member's current health condition. Practice Member hereby agrees to pay Provider in full for services performed by Provider. Practice Member and Provider acknowledge that Practice Member retains any and all rights to suit to procure payment for and benefit Practice Member may be entitled.

In Consideration of and for Provider rendering essential chiropractic and/or medical services to Practice Member, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service. Practice Member hereby authorizes and directs the following actions be taken on Practice Member's behalf.

I. PRACTICE MEMBER AUTHORIZATION TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Practice Member by Provider are privy of contact, and in lien of Provider sending direct billing to liability insurance carrier Practice Member authorizes and directs liability insurance company to disclose the settlement status of Practice Member's claim to Provider upon request, including settlement amounts thereof. After such time that the Practice Member has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Practice Member directs the liability carrier to include the name of Provider on any check to Practice Member upon such settlement. In the event payment is made to Practice Member's attorney after settlement of the claim. Practice Member further authorizes and directs the liability company to issue a check to Provider for the full amount owed for chiropractic and/or medical services rendered to fully satisfy Practice Member's obligation to Provider.

II. PRACTICE MEMBER AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Practice Member hires an attorney; Practice Member acknowledges that Practice Member is represented by _____ Attorney at Law. Practice Member and Provider stipulate that representation by the above-named attorney prior to settlement, judgment, or verdict in the Practice Member's claim. Provider shall have the option to terminate this agreement and immediately collect from Practice Member the full amount then owed to Provider. Practice Member directs attorney to disclose to Provider upon request the settlement status and amount of Practice Member claim to include amount of all outstanding medical bill, dollar amount of any offers and counteroffers as well as date and reason of termination or dismissal, Practice Member's last address, telephone number and place of employment known to attorney. Practice Member further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgment or verdict rendered in Practice Member's claim. Practice Member acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider for any unpaid account balance to Provider. This agreement survives this attorney-client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event the liability insurance carrier or Practice Member's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Practice Member's attorney the likely representative for Practice Member.

IV. PROMISSORY NOTE: For the consideration stated above; Practice Member promises to pay Provider the full balance in Practice Member's account for services rendered to Practice Member. Payment shall be due and payable within 30 days of the last date of services or within 3 (three) days of settlement with liability carrier for injuries sustained by Practice Member and treated by Provider, whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further, Practice Member agrees to the following:

IN THE EVENT PRACTICE MEMBER'S ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PRACTICE MEMBER AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PRACTICE MEMBER ACCOUNTS SHALL BECOME DELINQUENT. IF PRACTICE MEMBER'S ACCOUNT BECOMES DELINQUENT, PRACTICE MEMBER AGREES TO PAY COLLECTION AGENCY FEES AT 18% OF THE PRACTICE MEMBER ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICES. PRACTICE MEMBER FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Practice Member's account remains in active status. It is agreed that, in the event Practice Member terminates this agreement, Practice Member shall pay full balance of Practice Member's account within 3 (three) days of termination, or the account shall be in default. Practice Member and Provider acknowledge that this document contains full final and entire agreement between the parties. There are no other terms to this agreement. Practice Member has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void, it is expressly agreed by the parties that all remaining provisions shall remain in full force.

_____	_____	_____/_____/_____
Print Name	Signature	Date of Agreement
_____	_____	
Witness Signature	Provider	