EPIC Life
CHIROPRACTIC & WELLNESS

**….Welcome**

## Personal History

Full Name: _____ Preferred Name: _____
Address: _____ City: _____
State/Prov: _____ Zip/Postal Code: _____ Preferred Language: _____
Home Phone: _____ Birth Date: _____ Age: _____
Cell Phone: _____ Sex: [ ] Male [ ] Female
Social Security # _____ Circle One: Married Single Divorced Widow
E-Mail Address: _____
Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
Business Employer: _____ Type of Work: _____
Business Phone: _____
Spouse's Employer: _____ Name of Spouse: _____
Type of Work: _____ Name and Age of Children: _____
How were you referred to our office? _____
Name and Number of Emergency Contact: _____ Relationship: _____

## Current Health History

Purpose of this Appointment _____
Other Doctors seen for this condition: [ ] Yes [ ] No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? [ ] Yes [ ] No
Is Condition [ ] Job Related [ ] Auto Accident [ ] Home Injury [ ] Fall [ ] Other _____
Date of Accident _____ Time of Accident _____
Have you made a report of your accident to your employer? [ ] Yes [ ] No
Are You Currently Taking Any Medications? [ ] Yes [ ] No
Medication Name & Dosage Frequency Do You Have Any Medication Allergies [ ] Yes [ ] No
_____ _____
_____ _____
_____
Do You Wear a Shoe Lift? [ ] Yes [ ] No
Do you suffer from any other conditions *other than* that which you are now consulting us? _____
Name of Primary Care Physician: _____ Office #: _____

## Lifestyle

Do you exercise? [ ] Yes [ ] No How often? (Circle) [ ] 1x [ ] 2x [ ] 3x [ ] 4x [ ] 5x / per week/other _____
What activities? [ ] Running [ ] Jogging [ ] Weight Training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming
[ ] Other_____
Smoking Status: [ ] Everyday [ ] Occasional [ ] Former Smoker [ ] Never Smoked
Do you drink alcohol [ ] Yes [ ] No How much / week? _____
Do you drink coffee? [ ]Yes [ ] No How many cups / day? _____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____
Blood Pressure: [ ] Normal [ ] Low [ ] High Weight _____ Height _____

## Past Health History

Surgery / Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Ear Tubes/Adenoids
[ ] Broken Bones [ ] Back / Neck Surgery [ ] Other _____
Accidents or Falls: _____
Hospitalizations: (Other than above) _____
Previous Chiropractic Care: [ ] Yes [ ] None
Doctor's Name and Appointment Date of Last Visit: _____

## Health Conditions

Accumulation of Physical, Chemical and Emotional Stressors leads to Nerve Stress on your entire body. This nerve stress leads to a body that has challenges adapting, healing, functioning and feeling good. Slips, falls, accidents and abnormal postural habits lead to spinal misalignments which cause undetected nerve damage. Our food choice and prolonged uses of medications leas to toxicity and chronic emotional stress leads to hormone imbalances (adrenaline/cortisol). It has been extremely documented that accumulated nerve stress will weaken and distort the overall structure of your spine and will negatively impact overall organ function and health. The areas of nerve stress will determine the organs affected and its affect on your body's health.

1. Accumulated nerve stress in your neck (Cervical Spine) leads to the following. In the past or presently, have you experienced?

□ Low Energy/ Fatigue
□ Neck Pain
□ Headaches
□ Pain into the shoulders/arms/hands
□ Numbness/tingling in arms/ hands
□ Weakness in grip
□ Dizziness
□ TMJ pain/ clicking
□ Colic
□ Coldness in hands
□ ADD / ADHD
□ Sinusitis
□ Recurrent Colds/Flu
□ Hearing disturbances
□ Visual disturbances
□ Thyroid conditions
□ Allergies/ Hay Fever
□ Ear Infections

2. Accumulated nerve stress at you mid/upper back (Thoracic Spine) leads to the following. In the past or presently, have you experienced?

□ Heart Palpitations
□ Heart Mummers
□ Tachycardia
□ Heart attacks/ Angina
□ Recurrent Lung infections/Bronchitis
□ Asthma/Wheezing
□ Shortness of breath
□ Pain on deep inspiration/expiration
□ mid Back Pain
□ Pain into ribs/chest
□ Indigestion/heartburn
□ Reflux
□ Nausea
□ Ulcers/Gastritis
□ Hypoglycemia
□ Tired/Irritable after eating

3. Accumulated nerve stress at your lower back (Lumbar Spine) leads to the following. In the past or presently, have no experienced?

□ Pain into your hips/legs/feet
□ Numbness/ tingling in your legs/feet
□ Coldness in you legs/feet
□ Muscle cramps in your legs/feet
□ Constipation/Diarrheas
□ Bed wetting
□ Weakness/injuries in your hips/knees/ankles
□ recurrent bladder infections
□ Frequent/difficulty urinating
□ menstrual irregularities/cramping (females)
□ Sexual Dysfunction
□ Low back pain

## Consent to Care

I do hereby authorize the doctors of EPIC Life Chiropractic & Wellness to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable and necessary for my healthcare.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at he clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I authorize the doctors of EPIC Life Chiropractic & Wellness to discuss the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services rendered will be charged and I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of chiropractic there are some risks to treatment including, but not limited fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. The doctor will not be held responsible for any health conditions are diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees previously incurred will be due and payable at that time. I authorize the assignments of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be personally liable for any and all of the unpaid balance due to the Doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below to the above-above names procedure. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature_____ Date _____
(If under age 18) Parent Signature

**INSURANCE INFORMATION**

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing there services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credit to my account.

Signature _____ Date _____
(If under age 18) Parent Signature