



11056 Renaissance Drive Davidson, NC 28036 (844)-NCCHIRO www.inspirechiroandwellness.com

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Alternate Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Student: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## Your Health Profile

Welcome to Inspire Chiropractic and Wellness. Our goals are, first, to address the health concerns that brought you to this office, second, to offer you the opportunity to improve your overall health potential and well-being, and third, to answer any questions that you might have. Answering the following questions will give us a health profile allowing us to better assess your condition and help us address your current needs.

### Childhood Years

Research is showing that many of the health challenges that we face today have their origins during our developmental years, some starting as early as birth. Please answer the following to the best of your ability.

	Yes	No
Was your birth C-section, suction or forceps?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
Did you experience any abuse (physical or verbal) as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Did you experience any sports injuries as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Any childhood falls or accidents? (car, crib, tree, bike, bed....)	<input type="checkbox"/>	<input type="checkbox"/>
Was there any prolonged use of medications such as antibiotics, inhalers, Ritalin?	<input type="checkbox"/>	<input type="checkbox"/>
Did you suffer any emotional trauma or significant loss as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Were you checked for traumatic birth syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

## Adult Years

On a daily basis we experience physical trauma, chemical toxins and emotional stresses that can accumulate and result in a serious loss of our health potential. In most cases the effects are gradual, not even felt until they become serious.

	Yes	No
Do/ Did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do/ Did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been involved in any accidents (car, work, sports, falls)?	<input type="checkbox"/>	<input type="checkbox"/>

If so, please describe: \_\_\_\_\_

Do you participate in extreme sports? \_\_\_\_\_

Please list any surgery that you've had: \_\_\_\_\_

List all medications that you are taking: \_\_\_\_\_

## Your Current Health Status

On a scale of 1-10 rate your current state of health: (1=poor/ 10=excellent) \_\_\_\_\_

This visit is for a Wellness Evaluation:

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

This visit is for a specific area of complaint:

List your chief complaints in order of severity:

1. \_\_\_\_\_ For how long: \_\_\_\_\_
2. \_\_\_\_\_ For how long: \_\_\_\_\_
3. \_\_\_\_\_ For how long: \_\_\_\_\_

Where is the pain? \_\_\_\_\_

Does the pain radiate: \_\_\_\_\_

Is your discomfort:  Sharp  Dull  Burning  Aching  Come and Goes  Constant

Since your problem started, is it...  About the same  Getting better  Getting worse

Yes, it interferes with:  Work  Sleep  Hobbies  Leisure  Family life

Other health care providers seen for this condition:

Chiropractor: \_\_\_\_\_

Medical Doctors: \_\_\_\_\_

Other: \_\_\_\_\_

**Patient's or Authorized Person's Signature**-I authorize Inspire Chiropractic and Wellness to contact my primary care or other health care provider regarding my care and the release of any medical records or other information as necessary.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Please Check All That Apply

Please check all symptoms you have ever had, even if they don't seem related to your current problem.

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needle in legs | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Neck Pain   |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Back pain               | <input type="checkbox"/> Loss of balance       | <input type="checkbox"/> Dizziness   |
| <input type="checkbox"/> Ringing in the ears      | <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Numbness in fingers   | <input type="checkbox"/> Tension     |
| <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Upset Stomach           | <input type="checkbox"/> Frequent colds        | <input type="checkbox"/> Fatigue     |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Sleeping problems     | <input type="checkbox"/> Stiff neck  |
| <input type="checkbox"/> Cold hands or feet       | <input type="checkbox"/> Heart burn              | <input type="checkbox"/> Lack of concentration | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Menstrual problems       | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Chronic fatigue       | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Inability to lose weight | <input type="checkbox"/> Cardiovascular disease  | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Bladder problems        | <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Whiplash    |
| <input type="checkbox"/> Carpal tunnel syndrome   | <input type="checkbox"/> Colon problems          | <input type="checkbox"/> Disc problems         | <input type="checkbox"/> Migraines   |

## Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Wellness Chiropractor, please mention their name and condition below:

Children: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brothers or sisters: \_\_\_\_\_  
Others: \_\_\_\_\_

## Your Wellness Profile

	Yes	No
Do you belong to a health club/gym?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you meditate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you practice yoga?	<input type="checkbox"/>	<input type="checkbox"/>

## X-Ray Consent

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. I understand that results are not guaranteed. My condition may or may not improve with chiropractic care. You have the right, as a patient, 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.

Subluxations are corrected and/or reduced 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 specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

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.

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.

I have received a copy of the Notice of Privacy Practices for Protected Health Information. \_\_\_\_\_  
Initial

**The information made on this form is accurate and I agree to allow this office to examine me for further evaluation:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Health Insurance

### PAYMENT IS DUE AS SERVICES ARE RENDERED

Patients are responsible for payment at the time of their visit. Understand that health and accident insurance policies are an arrangement between an insurance company and you. Inspire Chiropractic and Wellness DOES accept assignment of insurance benefits, and as a courtesy we will verify your insurance. We will inform you of how much your insurance will likely contribute to your care, but verification is not a guarantee of payment.

**Patient's or Authorized Person's Signature**-I authorize the release of any medical or other information necessary to my insurance carrier to process my claims. I also request insurance payments be made directly to Inspire Chiropractic and Wellness Inc. I am aware that health insurance may deny coverage of care and I agree to pay for any denied services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

## Medicare

Inspire Chiropractic and Wellness is a participating Medicare provider. Medicare patients must present their Medicare card at the onset of treatment. Chiropractic coverage by Medicare includes adjustments only. For any other services, patients are required to pay cash as services are rendered. If you have a secondary insurance, please present that card with your Medicare card at the onset of treatment and we will verify your coverage and submit your claims as a courtesy to you.

**Patient's or Authorized Person's Signature**-I authorize the release of any medical or other information necessary to Medicare. I also request payment of government benefits to Inspire Chiropractic and Wellness Inc. I am aware that Medicare may deny coverage of care and I agree to pay for services not covered by Medicare.

Signature \_\_\_\_\_ Date \_\_\_\_\_