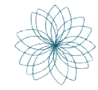

Vital Information

Name ____ Date ____/____/__________

I prefer to be called ____

Address ____

City ____ State _____ Zip __________

Home # _____-_____-______ Work # _____-_____-______ Cell # _____-_____-______

Preferred Contact # h | w | c Email ____

Birthday ____/____/__________ Age _____

Occupation ________________________________ Employer __________________________

Marital Status O Married O Domestic Partner O Single O Widowed

Spouse/Partner Name ____

Do you have children? y | n How many? _____

Names & Ages of all Children ____

____

Reason for seeking our services? ____

What other action steps have you taken? ____

Who can we thank for referring you to **SHINE Chiropractic**? ______________________________

Have you ever been adjusted by a Chiropractor? y | n

Who & Where? __________________________________ Date of last adjustment? ___/_____

Do you have a Primary Care Provider? y | n

Who & Where? ____

Is there anything about your Nerve System and Spine we should know about? __________

____

Additional comment(s) ____

____

____

Last Name: __________ First Name: __________ Date: ___/___/___

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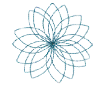


Last Name: ______________ First Name: ______________ Date: ___/___/___

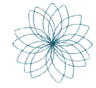
Stress Profile

Chiropractic is based upon the location and adjustment of vertebral subluxations. **Subluxations** are caused by any stress your body cannot properly perceive, adapt to, or integrate. These stresses may be physical, chemical, or emotional/mental in nature. Please circle the stresses that you've experienced as a child, teen, and adult.

Physical Stress:	**Child**	**Teen**	**Adult**	**None**	**Explain**
Birth Difficulty (as Mother or Child)	C		A	N	
Serious Slips/Falls	C	T	A	N	
Car Accidents	C	T	A	N	
Sports Injuries	C	T	A	N	
List Sports	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Sitting on Your Wallet for Years	C	T	A	N	
Not Enough/Poor Sleep	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Driving for Many Hours	C	T	A	N	
Continuous Hours Standing/Sitting	C	T	A	N	
Hospitalization	C	T	A	N	
Bone Fracture	C	T	A	N	
Surgery	C	T	A	N	
Other	C	T	A	N	

Emotional Stress:	**Child**	**Teen**	**Adult**	**None**	**Explain**
Difficult Break-Up/Divorce	C	T	A	N	
High Stress Career	C	T	A	N	
High Family Stress	C	T	A	N	
Money	C	T	A	N	
Recurrent Physical/Mental Illness	C	T	A	N	
Fast Paced Life	C	T	A	N	
Hold in Feelings	C	T	A	N	
Quick Tempered	C	T	A	N	
Verbal/Emotional Abuse	C	T	A	N	
Perfectionist	C	T	A	N	
Body Image Issues	C	T	A	N	
Made Fun Of/Teased	C	T	A	N	
Sickness or Loss of Loved One	C	T	A	N	
Difficulty Letting Go of Control	C	T	A	N	
Other	C	T	A	N	

Chemical Stress:	**Child**	**Teen**	**Adult**	**None**	**Explain**
Environment (i.e. Poor Air/Water)	C	T	A	N	
Smoker/ Second Hand Smoke	C	T	A	N	
High Sugar Consumption	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Energy Drinks	C	T	A	N	
Vaccinations	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over the Counter Drugs (Advil, etc.)	C	T	A	N	
Recreational Drugs	C	T	A	N	
Alcohol Use	C	T	A	N	
Antibiotics	C	T	A	N	
Work With Chemicals	C	T	A	N	
Poisoning	C	T	A	N	
Other	C	T	A	N	



Nutritional Background

Nutritional History (please check the items that apply to your typical diet)

O junk food (___ x's per week)
O microwave food (___x's per week)
O gluten-free
O vegan
O excess sugar
O artificial sweetener
O dairy-free
O omnivore
O skip meals
O no breakfast
O vegetarian
O raw food
O other special diet____

O water (# of glasses per day ____)
O soda
O caffeine
O alcohol
O energy drinks
O tea/coffee
O juice

Do you relate any of the experiences checked above to your current state of health? y | n
If yes, which ones?____

System Challenges

Has your body communicated any of the following to you? (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

O Headaches
O Allergies
O Ringing in Ears
O Vertigo
O Rashes/Eczema
O Sinus Problems
O Constipation/Diarrhea/Gas
O Digestions Problems
O Ulcers
O Low Back Pain
O Neck Pain
O Tension Across Top of Shoulders
O Tension Between Shoulder Blades
O Shortness of Breath
O Loss of Sleep
O Heartburn
O Heart Conditions
O High Blood Pressure
O Cholesterol
O Anemia
O Numbness in Arms/Legs
O Cold Hands/Feet
O Urinary Changes
O Weight Changes
O Sweats/Chills
O Night Sweats
O Dizziness
O Cancer
O Fatigue
O Asthma
O Arthritis
O Other________________________________
O Anxiety
O Depression/Nervousness
O Mood Swings
O ADD/ADHD
O Vision/Hearing Changes
O Stroke
O Hypo/Hyper Thyroid
O Prostate Changes
O Chest Pain
O Loss of Smell or Taste
O Stomach Problems
O HIV
O PMS
O Fever
O Diabetes

Questions for Women

O past pregnancy
O birth control pills/patch/ring
O currently pregnant
O painful periods
O breast-feeding
O irregular cycles

Other Avenues of Healing

Have you had or do you use any of the following for your growth, healing and development?

O Massage/Bodywork
O Emotional Therapy/Psychotherapy
O Physiotheraphy/Occupational Therapy
O Music/Dance/Sound/Light/Aromatherapy
O Yoga/Pilates/Dance/Tai Chi
O Homeopathy/Herbalist
O Naturopathic Medicine
O Ayurvedic Medicine
O Acupuncture
O Cranial-Sacral
O Nutritional Cleansing
O Nutritional Counseling
O Breathwork/Re-birthing
O Feldenkrais
O Other_______________

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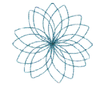

Date: ___/___/___ First Name: __________ Last Name: __________

Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.

1 = extremely dissatisfied. 10 = completely fulfilled.

Energy level	______
Clarity of thought	______
Physical Flexibility and Ease	______
Mental Flexibility	______
Emotional Balance	______
Level of Pain	______
Sleep quality	______
Connection to God/Spirit/Source	______
Feelings of Abundance	______
Level of Joy in Life	______
Relationships	______
Sense of Peace/Hope	______
Ability to Adapt to Change	______
Overall Health & Wellbeing	______

Clarifying Your Intentions

What do you hope to receive from our care? (i.e. full, abundant health and well-being, pain relief, reconnection of my spiritual/physical body, etc.)

____

What is your level of commitment to yourself, your life, healing and wellbeing?

High | Medium | Low

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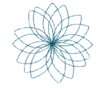


Philosophical Agreement

SHINE Chiropractic is affiliated with **Café of Life** which exists to make a positive contribution in your Life, by assisting you to heal naturally and to enjoy abundant health and wellbeing. **The Practice of Chiropractic** is based on ageless principles governing health and healing. They are briefly explained below so that you may understand how Chiropractic can help you.

Life Force is the sole difference between life and death. From the moment of conception until your last breath, Life Force is the essence that sustains you. You can live for some time without food, water, sleep, exercise and even air, yet you cannot live an instant without Life Force. Life Force is the essential ingredient in health and healing. It is the power that runs and heals your body. **Healing** is the creation of new cells to replace old, sick or damaged ones. Cellular replacement is how your body heals and repairs naturally. When new healthy cells are created regularly you stay well and healthy. Life Force is generated by the brain and flows through your spinal cord and nerve network to stir every tissue cell of your body into aliveness.

The **Nerve System** is also the medium used for the transfer of vital information essential for all Human Works- from healing to body functions, emotions, creativity, performance and self-expression. Your Nerve System is your link between the inner and outer world. It consists of the brain, the spinal cord, the nerves and the dazzling array of neurotransmitters. The extensiveness of the Nerve System is such that your Nerve System and **Immune System** are in fact one; therefore a Nerve System at ease rather than stressed or tense, leads to a stronger immunity. Your body functions at its best.

Blockages and interferences to your **Nerve System** develop throughout life from physical, emotional or chemical stressors. This interferes with your normal physiology. With time, dis-ease, mal-function, symptoms, sickness and disease manifest. These symptoms are the effects rather than the cause. **Chiropractic addresses cause rather than the effects.**

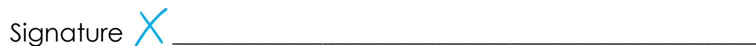
A **free flow in brain to body communication** enhances your ability to heal, repair and be healthy. When messages from your brain travel freely to all parts of your body, you express and experience Life fully. Healing, wellbeing, increased performance and greater personal expression are the natural byproducts.

Chiropractic adjustments free up Life Force and the flow of messages between the brain and body, by removing blockages and interferences to the Nerve System. It allows every individual whether a newborn, an athlete or a grandparent to heal, repair and experience more vitality. Due to a greater Life Force flow, all areas of a person's life improve. In some individuals, physical, emotional and/or mental challenges may clear up quickly; in others the process is slower or partial. Yet everyone will benefit on some levels. The power of the adjustment is remarkable.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. **Chiropractic specializes in the expression of life, health, wellness, healing and wellbeing.** Medicine specializes in the diagnosis and treatment of symptoms, sickness and disease. One is not exclusive of the other; both are separate and distinct professions.

Rather than diagnose, treat or prognose any physical, mental or emotional ailments which is the practice of Medicine, we free Life Force through adjustments. We share information and impart knowledge about natural healing, health, wellness and wellbeing, which is the practice of Chiropractic. Our primary goal is your health, healing process and wellbeing. We are here to support you.

I (We),________________________________&________________________________ the undersigned, have completely read and understood the above statement and choose to receive care.

Signature  Date _____/_____/___________

Last Name: ______________ First Name: ______________ Date: ____/____/____

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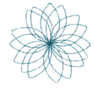

Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. A copy of our notice is available on our website (www.livelovethrive.com) and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- I give permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If SHINE Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to SHINE Chiropractic to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give permission to SHINE Chiropractic to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.
- I give SHINE Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.

By signing this form you are giving SHINE Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at SHINE Chiropractic more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at SHINE Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to SHINE Chiropractic. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it is received by SHINE Chiropractic.

Last Name: ____________ First Name: ____________ Date: ___/___/___

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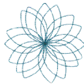


This AUTHORIZATION is requested by SHINE Chiropractic for its own use / disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, SHINE Chiropractic will provide care , however, it will not be possible for SHINE Chiropractic to file third party billing on my behalf and I will be responsible for: 1) payment in full at the time services are provided to me 2) scheduling my own appointments since SHINE Chiropractic will be unable to contact me 3) all contact with SHINE Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, with boundaries, the Protected Health Information to be used / disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN ________-______-______________________ D.O.B. _____/_____/___________

Name (Print) ____

Signature X ____________________________________ Date _____/_____/___________

Name of Personal Representative (If someone other than yourself is designated to act on your behalf)

Name (Print) ____

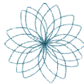
Personal Representative X ____________________________ Date _____/_____/___________

Description of Representative's Authority To Act On your Behalf:

____

____

Last Name: ______________ First Name: ______________ Date: ____/____/____



Insurance Policy

Recommendations for care are based on necessity and not insurance benefits. Please understand that insurance companies pay for sick-care, not wellness care as provided by SHINE Chiropractic. Many times your insurance benefits may contribute to the cost of your care here at SHINE Chiropractic. Your insurance policy is between you and your insurance company, not between your insurance company and us. We are happy to offer to do your insurance billing for you with full understanding that the cost for service rendered to you by SHINE Chiropractic is your personal responsibility. If applicable, we will accurately bill your insurance company for services.

ANTHEM BLUE CROSS/BLUE SHIELD or OTHER INSURANCE WHICH PAYS DIRECTLY TO PATIENT
If you request us to direct bill your insurance company which pays directly to you, our office policy is that you leave a credit card on your account to cover the costs in the event you should receive insurance checks for our services and not return them. The credit card will only be used should you fail to provide our office with the funds within 5 days of receiving them or call to let us know you will bring the checks on your next appointment. We receive updates from all insurance companies of insurance check disbursements.

I, ________________________________, understand it is my responsibility to return all Explanation of Benefits (EOB) and Reimbursement Checks to SHINE Chiropractic promptly. If I fail to do so within one week of receiving the check(s), I authorize charges to my credit card for the amount of the check(s).

Some insurance companies insist on sending you, the receiver of care, the insurance payment. It is your responsibility to bring in the insurance checks and Explanation of Benefits (EOB's) to SHINE Chiropractic. As any good organization, SHINE Chiropractic monitors payments and who receives them. If you fail to bring the check in to us, we have no recourse but legal means. Nobody wants this. So, to facilitate a smooth agreement, we have implemented a policy to have your credit card on file in the chance that you forget to bring in the money due SHINE Chiropractic.

Only fill out if you choose to utilize your insurance.

Name as shown on card ____
Credit Card Acct. #____ Exp. Date ____/_______
Type O VISA O MC O AMEX O DISCOVER 3 Digit Security Code __________ (4 digit for AMEX)

I CLEARLY UNDERSTAND AND AGREE that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office relating to my care. I also understand that I may suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable. I agree that if I fail to provide SHINE Chiropractic *with payments made in my name for services rendered at* SHINE Chiropractic, *I give* SHINE Chiropractic *the right to charge said credit card for the exact amount that the insurance company state was paid to me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.*

I (We),____________________________&____________________________ the undersigned, have completely read and understood the above statement concerning insurance and choose to receive care.

Signature X ____ Date ____/____/__________

Date: ___/___/___
First Name: ______________
Last Name: ______________

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