COLUMN CARE CHIROPRACTIC, LLC

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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. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

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

_____ _____
(signature) (date)

I, _____ being the parent or legal guardian of
_____

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(signature) (date)

PATIENT DEMOGRAPHIC INFORMATION

Last Name:_____ First:_____ M.I._____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home_____ Work:_____ Occupation:_____

Cell: _____ E-mail: _____

Employer's Name:_____ Employer's Address:_____

Social Security #:_____ Age:_____ Date of Birth:_____ Gender: [] M [] F

Single Divorced Married Widowed

Number of Children and Ages:_____

Spouse's Name:_____

Spouse's Employer and Work Number:_____

Other Nearest Relative or Contact Person:_____ Phone:_____

Type of care you are seeking: ☐ a current condition/problem ☐ health/wellness

Intended method of payment: ☐ cash/check ☐ credit/debit card ☐ insurance plan

How did you hear about us?_____

Have you ever had chiropractic care before? ☐ yes ☐ no

List the name of your health insurance company: _____

I understand that making an appointment is a verbal agreement and upheld as legally binding. I will then give 24 hours notice if a cancelation or rescheduling conflict arises. If I fail to do so I am responsible for the full amount of the visit under the discretion of the office manager.

Signature_____ Date: _____

Welcome to Chiropractic

Please Print Clearly and fill In completely.

Print Name _____

This questionaire will help us determine your starting point for chiropractic care, and offer insight to areas that may be of special concern. We are anxious to begin your care, however please be thorough and honest when answering these questions.

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any current Medications:_____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation:_____ Work Duties_____

Spouse's health status _____

Children's ages and health status:_____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name (optional) _____

Date of last chiropractic visit _____Reason for care_____

Date of last chiropractic x-rays _____How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who?_____

Wellness Commitment

At Column Care Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% ------- 20% ------- 30% ------- 40% ------- 50% ------- 60% ------- 70% ------- 80% ------- 90% 100%

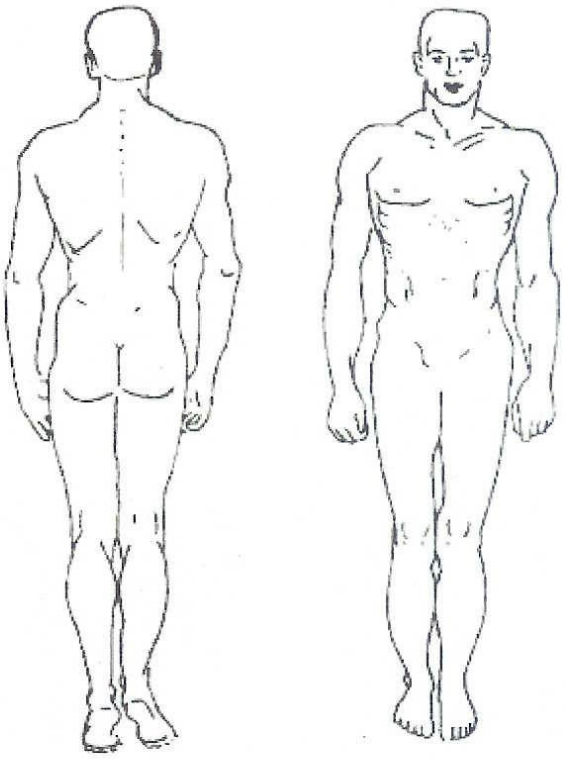
Please turn over and continue.

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Vision Changes	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Feminine Complications	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Frequent colds	❑	❑
Skin conditions	❑	❑
Other (list)_____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____