# GREATER LIFE WELLNESS CENTER

GENERAL INFORMATION-*Please print* Today's Date:_____

Patient Full Name_____ Date of Birth_____ Age____

Address_____ care of _____
*(Parent or financially responsible person)*

City_____ State_____ Zip_____

Phone (cell) _____ Phone (home)_____

E-mail _____

How would you like to be addressed?_____ Gender _____ No. Children _____

| Marital Status: Married Single Widowed Divorced<br>**Spouse's Name:** | Your Social Security Number<br>- - |
|---|---|

Patient's Employer or School_____

Address_____

City _____ State_____ Zip _____

***Occupation***:_____ *STUDENT*

*Full time Part time* *Full time Part time*

*Not employed Retired*

***Who may we thank for referring you?***

_____

*Your children's names & ages:*

_____

_____

_____

Your Emergency Contact Person:_____ Relationship_____

Address_____ Phone _____

*INSURANCE INFORMATION* **(Please allow us to make a copy of your card for Verification)**

| *Primary Insurance Company Name* | *Secondary Insurance Company Name* |
|---|---|
| *(800) Phone # _____*<br>*Policy/Group #_____*<br>*1st Insured's Name_____*<br>*Relation to you_____* | *(800) Phone #_____*<br>*Policy/Group #_____*<br>*1st Insured's Name_____*<br>*Relation to you_____* |

I understand and agree that;

- All first visit charges are payable when services are rendered.
- Any fee paid for x-rays is for analysis only. The film itself is the property of this office.
- Health and accident insurance policies are an arrangement between my insurance carrier and me.

I understand Greater Life Wellness Center will prepare any necessary reports and forms to assist in making collection from my insurance company, and that any amount authorized to be paid directly to Greater Life Wellness Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, I am personally responsible for payment, and I may be charged a finance charge of 1.5% per month on any outstanding balance due to me unless other payment arrangements have been made. I also agree to pay any and all fees that may be associated with any collection on my account. I certify that the information I give is true and understand that it is confidential.

Patient Signature_____Date_____

Guardian Signature Authorizing Care_____Date_____

**Physician List**

| Physician's Name | Specialty | Date of last visit |
|---|---|---|
| Physician's Name | Specialty | Date of last visit |

*Please* fill in appropriate spaces. (Confidential)

Name:_____ Date:_____

Your Main Complaint: _____ Severity (1-10):_____ % of time:_____

How long?_____ Date of Onset_____ Lost workdays? YES / NO How many?_____

When do you notice it most? AM / PM What makes it better?_____ Worse?_____

Type of pain~ Aching – Burning – Cramping – Dull – Throbbing – Numbness – Tingling ~ etc:_____

Accident related? NO / Auto / Work Date:_____ Similar condition before? YES / NO When?_____

Desire to fix problem: (1-10)_____ Concerns if not fixed:_____

Does it cause any **difficulty** performing any of the following activities?: (please circle all that apply)

Personal care – Lifting – Reading – Work – Driving – Walking – Sitting – Standing – Social life – Recreation

***Explanation~**_____

Previous Chiropractic care? YES / NO Date of last visit_____ Reason for initial visit_____

Recommended spinal maintenance from last Dr. of Chiropractic?_____

**Please check all conditions you have suffered or been diagnosed with:** (Specify Type & Right or Left)

____*__Surgeries__ (specify below)
____Neck pain / stiffness R L
____Numbness/tingling, pain in arms, hands, fingers R L
____Jaw pain or clicks R L
____Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
____Shoulder pain R L
____Dizziness
____Ringing in ears R L
____Hearing loss R L
____Blurred or doubled vision
____Upper back pain, stiffness
____Mid back pain, stiffness
____Lower back pain, stiffness
____Pain/ blood cough/ sneeze
____Hip pain R L
____Headaches/Migraines
____Numbness, tingling, pain in buttocks, legs, feet, toes R L
____*Head Trauma

____**Fractured bones*
____**Auto Accidents*
___*0-1 yrs ago*
___*1-5 yrs ago*
___*5 yrs or more*
____*Other accidents, falls*
____**Arthritis (specify type)*
____**Diabetes*
____*Convulsions, Seizures*
____*Skin problems*
____**Cancer (specify type)*
____*Frequent colds, flu*
____*Depressed / Irritable*
____*AIDS, HIV*
____*Anemia*
____**Allergies to anything*
____*Under stress*
____*Eating disorders*
____*Trouble sleeping*
____*Trouble concentrating*
____*Learning disability*
____*Mood Changes*
____*Epilepsy*

____*Foot trouble R L*
____*Chest pain, asthma*
____Trouble breathing
____Heart/Circulatory problems
____Pacemaker
____Stroke ~ Date:_____
____High/low blood pressure
____Varicose veins
____Liver trouble
____Gall bladder trouble
____Digestive problems
____Ulcers
____Hemorrhoids
____Prostate problems
____Impotence
____Kidney trouble
____*Tumors / Congenital Prob.
____Menstrual problems (PMS)
____Pregnant (NOW)
____Bed wetting
____Ear / Sinus Infections
____Alcohol or Drug addiction
____Smoke- How much_____

***Explanation~**_____
_____
_____
_____
_____

_____

_____

_____

## Medication & Vitamin List

| *Vitamin/ Medication Name* | *(non) or Rx Strength* | *Date Began* | *Date Stopped* | *Prescribed by Dr. or Self* |
|---|---|---|---|---|
| | | From-_____ | To-_____ | Dr or Self |
| | | From-_____ | To-_____ | Dr or Self |
| | | From-_____ | To-_____ | Dr or Self |

**Please list any moving vehicle accidents, falls, tramas or injuries, whether at home or other:**

Accident:_____Date:_____Type of injury:_____Did you receive care? Y/N

Accident:_____Date:_____Type of injury:_____Did you receive care? Y/N

Accident:_____Date:_____Type of injury:_____Did you receive care? Y/N

Accident:_____Date:_____Type of injury:_____Did you receive care? Y/N

Accident:_____Date:_____Type of injury:_____Did you receive care? Y/N

**Are there any other injuries or problem, minor or major, that the doctor should know about?**

_____

_____

_____

**What are your health goals?** _____

**How do you expect to achieve these goals?** _____

**Please list all exercise routines:** _____

_____

**In what position do you sleep?** _____

_____ _____

Signature Date

# Greater Life Family Chiropractic

## TERMS OF ACCEPTANCE

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.

I therefore understand chiropractic care on this basis.

_____ _____
(signature) (date)

**Consent to evaluate and adjust a minor child:**

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.

**Pregnancy Release:**

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. Date of last menstrual cycle. _____

_____
(signature)