INNATE LIFE
CHIROPRACTIC

VITAL INFORMATION

Date_____

All information is strictly confidential and is only available for Innate Life Chiropractic staff to serve you best.

First Name:_____ Last Name:_____

Preferred Name: _____ Age:_____ Gender:_____

Date of Birth: _____/_____/_____ Email:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Mailing Address:_____

City:_____State:_____Zip:_____

Marital Status: ☐Married ☐Single ☐Partnership ☐Widowed ☐Divorced Spouse's Name:_____

Name & Ages of Children:_____

Your Occupation:_____ Number of Hours/Week_____

Emergency Contact:_____Phone:(____)_____Relationship:_____

☐I have Medicare ☐The reason for this visit is from a recent auto accident.

How were you referred to Innate Life Chiropractic?_____

Reason(s) for seeking services at Innate Life Chiropractic:_____

_____

On the scale below, please mark the following:

'X' = current level of health 'O' = your *desired* level of health

What change(s) would you most like to experience with care in this office?

☐Symptom Relief/Temporary Relief ☐Restore Health ☐ Maintain Health

☐Wellness & Prevention ☐ Improved Performance ☐ Expand Level of Well-Being

☐ Other:_____

Since the nervous system controls EVERYTHING in your body, it is quite likely that many areas of your health can be improved by care in our office. What other specific goal(s) might you have?

☐ Better sleep ☐ More energy ☐ Keep up with children/grandchildren

☐ More joy and ease ☐ Cease medication ☐ Reach full potential

Are there any other goals do you have for your life :_____

_____

What is your current level of dedication to yourself, your life and well-being? (circle)

None 1 2 3 4 5 6 7 8 9 10

Starting from birth, stresses and traumatic events can damage the spine and nerve system. Understanding the different PHYSICAL, CHEMICAL, and/or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as completely as possible.

HISTORY OF PHYSICAL STRESSES (BIRTH TO PRESENT)

Was **your** birth: (check all that apply)

☐at home ☐birth center ☐natural ☐hospital ☐drug induced

☐C-section ☐prolonged ☐breech ☐cord around neck ☐forceps/suction

Have you ever: ☐Fallen down the stairs ☐Slipped and Fell ☐Stress/Strain at work

Have you ever injured your spine (neck, head, back, hips)? ☐ Yes ☐ No

If yes, please explain how and when:_____

What sports are/were you involved in? _____

☐ Sports injury –If so, please describe:_____

☐ Broken a bone -- If so, which ones?_____

☐ Other Injuries: _____

☐Auto collisions:_____

☐ Surgery -- if so, when & for what condition(s)? _____

_____

☐ Hospitalizations -- if so, when & for what condition(s):_____

_____

☐ Chronic Illness(es) -- Explain: _____

_____

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur due to any substance that is breathed, injected, taken by mouth, or placed on the skin

Do you or have you ever taken: ☐Prescription drugs ☐Over the Counter Drugs ☐Recreational drugs

Have you been vaccinated? ☐Yes ☐No

Have you been exposed to: ☐Chemicals ☐Fumes ☐Dust ☐Smoke ☐Radiation/Chemotherapy

Do you regularly consume: ☐Alcohol ☐Coffee/caffeine ☐Tobacco

Medications you currently take:

☐NSAID'S (Advil, etc.) ☐Statins ☐Blood Pressure ☐Painkillers

☐Muscle Relaxers ☐Allergy ☐Anti-Depressants ☐Cold Medications

☐Hormones ☐Other: _____

HISTORY OF EMOTIONAL STRESSES

It is impossible to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

Childhood Trauma	Loss of loved one	Relationships	Family
Work or School	Divorce/separation	Financial hardship	Abuse
Lifestyle Change	Parent's divorce	Illness	Other:_____

QUALITY OF LIFE

How do you grade your physical health? ☐Good ☐Fair ☐Poor

How do you grade your emotional/mental health? ☐Good ☐Fair ☐Poor

How do you grade your overall quality of life? ☐Good ☐Fair ☐Poor

How many Medical Doctor office visits did you have last year? ☐0 ☐Less than 5 ☐6 – 10 ☐10+

WORK & FAMILY HISTORY

Job Satisfaction: 1 2 3 4 5 6 7 8 9 10 Daily Stress Level: 1 2 3 4 5 6 7 8 9 10

Does your work negatively impact your health? ☐Yes ☐No If so, how_____

Are you satisfied with your home life? ☐Yes ☐No Do you have a clear purpose in life? ☐Yes ☐No

If so, please share your purpose:_____

CHIROPRACTIC HISTORY

Has you ever received Chiropractic care? ⛁ Yes ⛁ No Date of last adjustment? _____

Reason for previous chiropractic care?_____

What care plan was given?_____

HELP US SERVE YOU BETTER

Which best describes your reason for consulting our office?

☐ I have a specific concern and require your help with this concern

☐I want to ensure that my health concerns do not become an ongoing problem, impacting my future health.

☐ I want to be healthier five years from now than I am today

CURRENT CONDITION INFORMATION (if applicable)

Primary Concern (if any)?_____

When did it begin (date)? _____What caused it? _____

How did the condition start? ▢ Suddenly ▢ Gradually ▢ Post-Injury

Please rate the severity of this problem on average:

Low – 1 2 3 4 5 6 7 8 9 10 – High

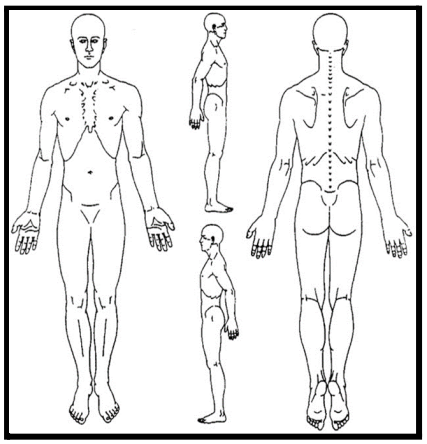
Today: Low – 1 2 3 4 5 6 7 8 9 10 – High

Is it: ▢Sharp ▢Stabbing ▢Burning ▢Achy ▢Dull ▢Stiff

▢Sore ▢Numb ▢Pins & Needles Other:_____

Does it radiate/shoot to any other areas of the body? ▢ Yes ▢ No

If YES, where:_____



Please draw the area of concern

How often do you experience this problem?

☐ Occasionally ☐ Intermittent ☐Frequent ☐ Constant

Is the condition: ▢ Getting Worse ▢ Staying the Same ▢ Improving ▢ Comes & Goes ▢ Unsure

What makes it better?_____

What makes it worse? _____

Is the condition worse at times of the day? ▢ No ▢ Morning ▢ Afternoon ▢ Evening ▢ Night

Have you ever had a similar condition? ▢ Yes ▢ No Please Explain_____

Is this concern interfering with:

▢Work /School ▢Sleep ▢Hobbies ▢Daily Routine ▢Exercise/Sports

▢Driving ▢Walking ▢Eating ▢Sitting ▢Love Life

Are you ***currently*** experiencing any of the following? Please check all that apply.

GENERAL
___Unintended Weight Loss
___Fever
___Chills / Night sweats
___Low Energy level/ Fatigue
___Night Pain
___Irritability
___Trouble sleeping

HEAD & NECK
___Head injuries
___Frequent/recurrent headache
___Concussions
___Lumps
___Swollen Glands
___Stiffness
___Thyroid problems
___Neck problems
___Jaw pain, TMJ

MUSCULAR/BONE
___Muscle pain or cramps
___Weakness
___Scoliosis
___Swollen or painful joints
___Deformity of hands or feet
___Neck Pain
___Mid Back Pain
___Low Back Pain
___Arm Problems
___Leg Problems

NEUROLOGICAL
___Headaches
___Vertigo
___Convulsions/Epilepsy/Seizures
___Numbness and/or Tingling
___Paralysis
___Tremors
___Pain with cough/sneeze
___Dizziness or Light headed
___Loss of balance
___Ringing in ears

GI/Bowels
___Heartburn/Reflux
___Abdominal pain
___Diarrhea
___Constipation
___Bloody/Black/Tarry stool
___Change in bowel habits
___Prolonged bloating
___Ulcers
___Digesting issues
___ Crohn's/IBS/Ulcerative Colitis

MIND
___Nervousness
___Depression
___Insomnia
___Mood changes
___Eating disorder

HEART & CARDIOVASCULAR
___Chest Pain
___Palpitations
___Fainting
___Shortness of breath
___Leg cramps
___Leg swelling
___Blood clots
___Anemia
___Easy bruising
___Wounds take excessive time to heal

LUNGS
___Prolonged cough
___Coughing up mucus/sputum
___Coughing up blood
___Sleep apnea
___Difficulty breathing
___Asthma

GLANDS
___Intolerance to heat or cold
___Appetite changes
___Excessive thirst
___Swollen or tender glands

SKIN
___Rashes
___Lumps
___Sores
___Dryness
___Changes in hair
___Changes to nails
___Changes in moles

EYE, EAR, NOSE, THROAT
___Vision Changes
___Redness
___Double /Blurred Vision
___Hearing Loss
___Discharge
___Frequent colds/flu
___Hay fever
___Allergies
___Nose bleeds
___Sinus/drainage problems
___Frequent sore throat
___Hoarseness of voice
___Sore / Swollen tongue
___Difficulty swallowing

BLADDER
___Visible blood
___Burning
___Change in urinary habits
___Difficulty passing urine
___Urgency/ Increase frequency
___Incontinence
___Kidney stones
___Up multiple times at night

REPRODUCTIVE
___Pregnant
___Irregular cycle
___Irregular / excessive bleeding
___Menopause
___PMS
___Fertility issues
___Sexual problems
___Breast lumps
___Nipple or skin changes
___Nipple discharge
___Prostate problems
___Impotency/Sexual Dysfunction
___ GentitalDischarge

THANK YOU FOR ANSWERING THESE QUESTIONS.
PLEASE CONTINUE TO THE NEXT PAGE.

AGREEMENT OF PAYMENT FOR SERVICES

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making a collection from the insurance company. If I determine that my insurance plan will reimburse me for chiropractic care in this office, ILC will provide me with itemized statements for me to submit**.**

I clearly understand and agree that all services rendered to me are charged directly to me. And I understand that I am personally responsible for the payment of my account.

It is the policy of this practice to collect for services as they are rendered, unless other financial arrangements are made. If at any point, a patient must cancel the remainder of their care plan they are entitled to a refund of the remaining balance. A refund will not be given for services that have been previously rendered.

Patient Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that you understand both the objective and the method used. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is to improve and optimize the health and well-being of the spine and nerve system, through the adjustment of Vertebral Subluxations

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

Subluxation : A misalignment of one or more of the 24 vertebrae in the spinal column which causes altered function of the nervous system and interference to the transmission of nerve signals, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment : Our chiropractic method of correction of a vertebral subluxation is by specific adjustments, either by hand or instrument, to the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area. 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 clear major interference to the expression of the body's innate wisdom and improve the function of the spine and nervous system. Our only method is specific adjusting to improve the health of the spine and nervous system.

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

Patient Signature _____ Date _____

CONSENT TO TREAT A MINOR (if applicable)

I certify that I, _____, am the child's parent and/or legal guardian and responsible for making their health care decisions. I hereby authorize Dr. Nathan Gerowitz and whomever he may designate as his assistants to administer care, as he deems necessary to my child _____.

I also grant permission for Dr. Nathan Gerowitz to provide care for my child if I am not present.

Date _____/_____/_____ Signed_____

Please Read and Sign

By signing this form, I understand that:

1. I agree that I am responsible to pay for all services I receive in this office.
2. I understand that most care is given in an open setting. Private rooms are available upon request.
3. A copy of Innate Life Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review at innatelifechiro.com/hippa/
4. I consent to receive communication from ILC in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.
5. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to ILC. If I should withdraw my consent, I will notify the office in writing.
6. I consent to my testimonial being used in office and electronically with my first name and last initial only. If I should withdraw my consent, I will notify the office in writing.
7. I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.

May we discuss your condition with any member of your family? YES NO
If YES, please name the members allowed. Release of Information includes the diagnosis, records, and examinations rendered to me and claims information.

[ ] Spouse _____

[ ] Child _____

[ ] Other _____

Print Name:_____

Signature:_____

Date: _____/_____/_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date: