Date:_____

DISCOVERY QUESTIONNAIRE

INNATE LIFE CHIROPRACTIC

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 ☐Divorced ☐Widowed 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:_____

_____

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

On the scale below, please mark the following:

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

What are your top 3 goals:

1. _____
2. _____
3. _____

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 goal(s) might you have?

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

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

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? ☐ Yes ☐ No Date of last adjustment? _____

Reason for previous care?_____ How long under care? _____

Why did you stop care?_____

WORK & FAMILY HISTORY

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_____

Do you have a clear purpose in life? ☐Yes ☐No If so, please share:_____

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

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 nervous system assists us in serving you. Please answer the following questions as completely as possible.

HISTORY OF PHYSICAL STRESSES (BIRTH TO PRESENT)

Research indicates that the birth process can cause trauma to a baby's spine & nervous system. Was **your** birth:(check all that apply)

☐home ☐birth center ☐hospital ☐natural ☐C-section ☐induced ☐cord around neck ☐forceps/suction

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

Please describe?_____

☐ Injured your spine (neck, head, back, hips)--please explain:_____

_____

☐ Other Injuries: _____

What sports are/were you involved in? _____

☐ Sports injury –If so, please describe:_____

☐ Auto collisions:_____

☐ Surgeries or Hospitalizations -- 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 Do you regularly consume: ☐Alcohol ☐Coffee/caffeine

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

Smoking/Vaping: ☐Every day ☐Some days ☐Former ☐ Never

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:_____

CURRENT CONDITION INFORMATION (if applicable)

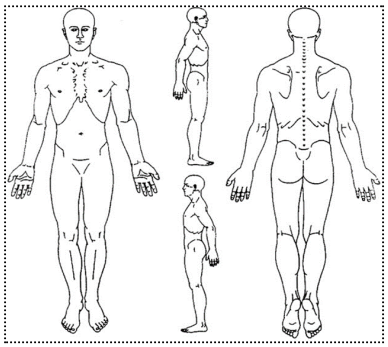
Primary Concern?_____ When did it begin (date)? _____

What caused it? _____ It began: ▢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

Is it: ▢Achy ▢Burning ▢Dull ▢Sharp ▢Stabbing ▢Sore ▢Stiff ▢Numb ▢Pins & Needles Other:_____

Please draw the area of concern⬇



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

If YES, where:_____

What makes it better?_____

What makes it worse? _____

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

If YES, Explain:_____

How often do you experience it? ▢Occasionally ▢Intermittent ▢Frequent ▢Constant

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

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

Have you seen anyone else for this? ▢Yes ▢No If so, whom:_____

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
___Frequent/recurrent headache
___Concussions
___Swollen Glands
___Stiffness
___Neck Pain
___Jaw pain, TMJ

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
___Fainting

MIND
___Nervousness
___Depression
___Insomnia
___Mood changes
___Eating disorder

GI/BOWELS
___Heartburn/Reflux
___Diabetes
___Abdominal pain
___Diarrhea
___Constipation
___Nausea/Vomiting
___Bloody/Black/Tarry stool
___Change in bowel habits
___Prolonged bloating
___Ulcers
___ Crohn's/IBS/UC

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

HEART & CARDIOVASCULAR
___Chest Pain/Palpitations
___Blood Pressure Problems
___Blood clots
___Anemia
___Swelling of hands/feet/ankles

GLANDS
___Thyroid problems
___Intolerance to heat or cold
___Appetite changes
___Excessive thirst
___Swollen or tender glands
___Autoimmune Disorders

SKIN
___Rashes/Itching
___Lumps/Sores
___Changes in hair/moles/nails

EYE, EAR, NOSE, THROAT
___Vision Changes
___Double /Blurred Vision
___Hearing Loss
___Frequent colds/flu/sore throat
___Hay fever/ Allergies
___Sinus/drainage problems
___Difficulty swallowing

BLADDER
___Visible blood
___Burning/Painful Urination
___Change in urinary habits
___Urgency/ Increase frequency
___Incontinence /Bedwetting
___Kidney stones
___Up multiple times at night

REPRODUCTIVE
___Pregnant
___Irregular cycle
___Irregular / excessive bleeding
___Menopause
___PMS
___Fertility issues
___Sexual problems/dysfunction
___Breast lumps/pain
___Nipple or skin changes
___Prostate problems

PLEASE CONTINUE TO THE FOLLOWING PAGES.

Agreement of Payment for Services

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.**The fee for a new patient is $150.00, which includes a chiropractic exam, a report of findings, and the first adjustment.** 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 seeking reimbursement from the insurance company, 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.** 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.

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 towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

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.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

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.

Right to Privacy

We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability Act of 1996, revised in 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

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.

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 have read and fully understand the Terms of Acceptance.
3. I understand that most care is given in an open setting. Private room available upon request.
4. A copy of Innate Life Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" is available for my review at innatelifechiro.com/hippa/
5. I consent to receive communication in connection with my care via email, postal mail, text & phone messaging.
6. I consent to my first name& last initial being posted on the Referral Board when I refer a new patient to Innate Life Chiropractic.
7. I consent to my testimonial being used in office/electronically with my first name &last initial only.
8. I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials.
9. I have read, or have had read to me, the above Informed 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.

If you remove consent to any portion please write it here:

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 _____

Patient Name: _____Signature: _____Date:
Parent or Guardian: _____Signature:_____Date:

<u>CONSENT TO TREAT A MINOR (if applicable)</u>

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.

Signature_____**Date** _____