FLOWER OF LIFE
CHIROPRACTIC

FEMALE NEW MEMBER HEALTH SURVEY

Name_____ Sex:☐M ☐F DOB___/___/___ Age_____

E-mail_____@_____.com Phone _____

Address_____ City_____ State_____ zip _____

Partner's Name _____ Sex:☐ M ☐F Phone _____

Names of Child(ren) & Age(s)_____

How did you find our office? _____

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

We are going to ask you a variety of questions that give us more information about your past and present experiences. These experiences affect your physiology and directly affect your physical, mental, emotional and spiritual wellbeing. These experiences fall into three categories; physical (trauma), mental/emotional/spiritual (thoughts) and chemical (toxins). If any experience was too much for your system to handle it can lock into your body as a tonal shift (tension) which can lead to a variety of symptoms. Please fill out the intake to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.

YOUR ARRIVAL - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on mom but also on baby.*

While in utero did your mother: ❑ Drink ❑Smoke ❑ On Medication ❑ Use Drugs ❑ High stress ❑ Accident

Was your birth: ❑ Vaginal without assistance ❑ Vaginal with Assistance ❑ Forceps ❑ Vacuum Extraction

❑ C- Section ❑ Induced labor ❑ Medications given_____

Where were you born? _____

Any complications? _____

PHYSICAL- *Thinking all the way back to your childhood have you had any of the following?*

Surgery (& year performed) : _____

Accidents: _____

Falls: _____

Sports/ Exercise (past & present): _____

Have you had a Breast Augmentation / Reduction / Removal? ❑ Y ❑ N (Please circle) Year(s)_____

Duties/Habits: ❑ Sit more than an hour ❑ Carry equipment or tools on your body ❑ Repetitive bend or twist

❑ Cradle the phone to ear L or R ❑ Drive on the Job ❑ Lift more than 10 lbs. repeatedly

Number of Previous Pregnancies: _____ Have you had a miscarriage or abortion? ❑ Y ❑ N When? _____

Type of birth: ❑ Vaginal ❑ Cesarean (❑ ER or ❑ planned)

Please mark Intervention : ❑ Induction: (❑ Membrane Sweep ❑ Cytotec ❑ Ptocin ❑ Foley Balloon) _____wks
❑ Medication ❑ Antibiotics ❑ Epidural ❑ Ruptured membranes ❑ Episiotomy ❑ Forceps / Vacuum How

long did you labor at home? _____ Hours Laboring _____ Time pushing _____

Please provide a timeline of laboring/birthing / Postpartum: _____

_____

Did You: ❑ Delay Cord Clamp ❑ Skin to Skin right away ❑ Hemorrhage ❑ Baby was separated for _____ time
❑ Complications with baby after birth ❑ Difficulty Delivering Placenta ❑ Baby latched right after birth Delivery
❑ Tearing ❑ Slow recovery ❑ Postpartum Blues ❑ Breastfeed How Long? _____

My Birth Experience was… _____

Are you Currently: ❑ Consciously Pre-Conceiving ❑ Conceiving ❑ Pregnant Guess (due) Date: _____

Conscious Conception? ❑ Y ❑ N Fertility Issues? ❑ Y ❑ N Fertility Measures Taken? ❑ Y ❑ N

Share Fertility Journey: _____

Third trimester presentation: ❑ Head Down ❑ Transverse Lie ❑ Breech ❑ Posterior Lie

Do you have: ❑ OBGYN ❑ Midwife ❑ Doula ❑ Lactation Consultant ❑ Postpartum Doula/ Baby Nurse

Have you experienced any of the following during this pregnancy: ❑ Morning Sickness/Vomiting/Nausea

❑ Sciatic Pain ❑ Heartburn ❑ Bladder/ Kidney Infection ❑ Difficulty Sleeping ❑ Constipation

❑ Low back Pain ❑ Headaches ❑ Pregnant with Multiples ❑ Gestational Diabetes ❑ Indigestion

❑ Pubic bone Pain ❑ Varicose Veins ❑ Placental Dysfunction ❑ High Blood Pressure ❑ Hemorrhoids

CHEMICAL STRESS - *Anything you inhale, ingest or absorb*

Are you currently taking/ have you taken birth control? How long? Type?_____

Current Medications (Name, Dose & Taken Since) : _____

_____

Previous Medications including antibiotics (Name & When/ how long taken) _____

_____

Do You: ❑ Drink Alcohol _____x / week ❑ Use Drugs ❑ Smoke _____ packs / week
❑ Drink Soda ____x / week ❑ Eat Packaged Food ❑ Use Air Purifier
❑ Eat Organic _____% ❑ Use Water Filter ❑ Use Shower Filter
❑ Sugar in Coffee ❑ Eat Non GMO ❑ Drink ____ oz of H20 / day

Current Diet: ❑ Vegetarian ❑ Pescatarian ❑ Vegan ❑ Keto ❑ Paleo ❑ Dairy-free ❑ Soy-Free ❑ Gluten-Free

❑ Other ❑ Chicken ❑ Fish _____x / week ❑ Red Meat _____x / week

What do your typical meals look like?

Breakfast: _____

Lunch: _____

Dinner: _____

EMOTIONAL / MENTAL STRESS: These stresses have a major affect on how our body processes and feels.

Occupation _____ Do you enjoy what you do: ❑ Y ❑ N ❑ S

Have you ever experienced the following?

❑ Mental Abuse ❑ Physical Abuse ❑ Sexual Abuse ❑ Major move ❑ Loss of a loved one
❑ Rapid life change ❑ Career change ❑ Being far from family/friends ❑ Financial Concern
❑ Divorce/ Separation ❑ Loss of Child ❑ Care provider for child/children ❑ Care Provider for parent

_____

_____

CURRENT HEALTH CONCERNS

What is the reason for this reservation?_____

When did this begin?_____ Have you had this before? _____

Why do you think this is occurring?_____

Is there any other issue/secondary condition that you believe is related to this?_____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

_____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? ❑ Y ❑ N If yes, when? _____

Does it affect: ❑ Mood, patience, attitude ❑ Sleep ❑ exercise or play ❑ day-to-day activities ❑ Ability to work

❑ decision making ❑ relationship or intimacy

What are your healthcare goals? _____

SECONDARY CONDITIONS- Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.

Past	Now		Past	Now	
☐	☐	ADD / ADHD	☐	☐	Headaches
☐	☐	Anemia	☐	☐	Herniated Disc
☐	☐	Anxiety	☐	☐	High Blood Pressure
☐	☐	Asthma / Respiratory Issues	☐	☐	Insomnia / Sleep Issues
☐	☐	Arthritis	☐	☐	Knee / Ankle / Hip Issue
☐	☐	Athletic Injuries	☐	☐	Mastitis
☐	☐	Autoimmune Disorder	☐	☐	Menstrual Problems / Pain
☐	☐	Back Pain	☐	☐	Multiple Sclerosis / ALS
☐	☐	Bowel / Bladder Changes	☐	☐	Neck Pain
☐	☐	Cancer	☐	☐	Numbness / Tingling
☐	☐	Concussion / Head Injury	☐	☐	Reproductive Organ Issue
☐	☐	Dental / Jaw issues / Braces	☐	☐	Scoliosis
☐	☐	Depression	☐	☐	Skin Condition
☐	☐	Diabetes	☐	☐	Sinus Problem / Allergies
☐	☐	Digestive Issues	☐	☐	Stroke
☐	☐	Dizziness / Vertigo	☐	☐	Surgery
☐	☐	Ear / Hearing Issues	☐	☐	Thyroid Disorder
☐	☐	Eye / Vision Issues	☐	☐	Urinary Tract Infections
☐	☐	Frequent Cold / Flu	☐	☐	Weight Changes
☐	☐	Fatigue / Brain Fog	☐	☐	Wrist / Elbow / Shoulder Issue
			☐	☐	Other _____

YOUR HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS ECT)

Provider Name Provider Type Last Visit Reason Result

_____

_____

_____

_____

Patient Signature _____ Date _____

Entered into Computer _____ initial _____

Informed Consent

We encourage and support a shared decision making process between us regarding your health needs. As part of that process, you have a right to be informed about the condition of your health, recommended care, and treatment. By providing with this information, you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science that concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and / or does not move properly. This subluxation causes interference or irritation to the nervous system. The primary goal in chiropractic care is the removal and / or reduction of nerve interference caused by vertebral subluxations.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpitation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce more correct vertebral subluxation(s). There are a number of different methods or techniques by which chiropractic adjustment is delivered, but are typically delivered by hand. Some clients may require the use of an instrument or other specialized equipment . In addition, physiotherapy or rehabilitative procedures may be included in the wellness management protocol. Among other things, chiropractic care may reduce pain, increased mobility, and improved quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care period the risks are seldom high enough to contraindicate care in all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care. This includes the risk that care received may not accomplish the desired objective. Reasonable alternative treatments have been explained including the risks, consequences , and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraph. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Flower of Life Chiropractic to proceed with chiropractic care and treatment. Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature Doctor’s signature

Notice of Privacy Practices for Protected Health Information

This Notice of Privacy Practices for Protected Health Information (PHI) describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Flower of Life Chiropractic to use and/or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATION (Please Read & Initial):

_____ I give permission to Flower of Life Chiropractic to use my address, phone number, and e-mail to contact me with appointment reminders, missed appointments, birthday cards, and newsletters.
_____ I would NOT like to receive Text Appointment Confirmations / Reminders
_____ I would NOT like to receive E-mail Reminders Confirmations / Reminders

_____ If Flower of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

_____ I give Flower of Life Chiropractic permission to adjust me in the adjustment suite which is a room where 1-3 other clients may also be getting adjusted. I am aware that other persons may overhear some of my protected health information during the course of care if I share that information in the open suite. I am aware that Flower of Life chiropractic can provide private space for any conversation about private health information if desired.

_____ I give Flower of Life Chiropractic permission to be in contact and Co-Manage my care with another member of my Health Care Team.

_____ I would like to request itemized statements for insurance reimbursement purposes.

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

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this authorization, in writing, at anytime. 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 the privacy official of flower of life chiropractic. The written notice must contain all of 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
Your signature

The revocation is not effective until it is received by the privacy official this authorization is requested by Flower of Life Chiropractic for its own use slash disclosure of PHI. (*minimum necessary standards apply)*

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, Flower of Life Chiropractic will not refuse to provide treatment. I will be personally responsible for:
1) Payment in full at the time of services that are provided to me
2) Scheduling my own appointments since Flower of Life Chiropractic will be unable to contact me
3) All contact with Flower of Life Chiropractic regarding my care.

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

Patient's Name (please print): _____

Patient or Guardian's Signature: _____ Date: _____

ADULT ASSESSMENT

Name_____ Asmt #_____ Date___/____/___ Cat_____ Score_____%

Structural Assessment: ____

L R ___Iliac Crest
L R ___AC joint
L R ___L R ___Ears
L R ___Listing/Antalgia
L R ___Head Rotation
L R ___Ear-shoulder-hip-knee-ankle/ Ant/Post lean
L R ___C curve hypo or hyper/ ant/ post head carriage
L R ___T-kyphosis hypo or hyper/ scap- carriage Ant or Post
L R ___L-Lordosis hypo or hyper/ swayback or flattening
L R ___Pelvic Carriage: Ant Crest tilt or coccyx tuck

Fakuta: - Ft forward (-1)_____ Shift (-1) L R Turn (-3) L R _____ ____
Sway: Forward/Backward (8) Side-to-Side (5) Antalgia: L R (3) ____
Scales: L _____ R _____ (every 5 lbs = -1) ____
ROM: ____

C: Flexion:50 (N M Mo S) (D S R) L: Flexion: 25 (N M Mo S) (D S R)
Extension:60 (N M Mo S) (D S R) Extension:30 (N M Mo S) (D S R)
L Rotation:80 (N M Mo S) (D S R) L Rotation:30 (N M Mo S) (D S R)
R Rotation:80 (N M Mo S) (D S R) R Rotation:30 (N M Mo S) (D S R)
L Lateral:45 (N M Mo S) (D S R) L Lateral:25 (N M Mo S) (D S R)
R Lateral:45 (N M Mo S) (D S R) R Lateral: 25 (N M Mo S) (D S R)

Primitive Reflexes: Rooting - + Palmer - + Gallant - + Babinski - + ATNR - + ____
Reflexes/Dermatomes: _____ ____
Leg Length: L R 0 ⅛ ¼ ½ ¾ ____
Heel tension: L: N D I R: N D I ____
Leg Leg: L R M Mo S BP ____
Sacral Dural Pump: O: P L A S: P L A (0,5,7,10) ____
Disconnections: _____(-1 per) ____
Soft Tissue Subluxations: 1 2 3 4 5 6 (3,7,10) ____
Osseous Subluxations: _____(-2 per) ____
Orthopedic Tests:
Justification _____ ____
Cervical compression **+ -** _____
Cervical distraction **+ -** _____
Shoulder depressor **+ -** _____
SLR **+ -** _____
KEMP **+ -** _____
Valsalva **+ -** _____
Other_____
Protocol: Blocking- Cat 1 Cat 2 Cat 3 Webster- L R Cranial

Notes:

_____
_____
_____

- FOR OFFICE USE ONLY -