· REID ·
Family Wellness

Welcome to REID FAMILY WELLNESS!

It is our mission and passion to help you attain your health goals. In order that we may best serve you in meeting your health needs, our job is to find the **cause** of your symptoms, and to improve your neurological function; that is, to get your nervous system back into balance! Once this goal is achieved, signs and symptoms will dissipate.

Please answer the following questions:

1. Where in your body do you hold or carry your stress?

2. What tools have you used to try to reduce your stress?

3. Do you consider your stress an external challenge, or an internal response to an external challenge?

4. Why do you think your body failed to heal itself **this** time?

5. Do you know why your brain and nervous system are called your 'Master Control System'?

6. How would you rate your daily level of stress (physical, chemical, emotional, time, money, family, work, relationships, etc.?) on a scale of 0 to 10, 10 being extremely high stress?

7. How would you rate your ability to sleep on a scale of 0 to 10, 10 being chronic insomnia?

8. What caused your pain?

9. Would you prefer care that only addresses your symptoms and ignores the cause, or, care that addresses the cause of your challenges?

We have something of greater value in our office. As such, we will be performing a Stress Response Evaluation (SRE) to help us determine the cause of your symptoms and your most efficient and effective plan of care.

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Please check all symptoms you have ever had, even if they do not seem related to your current problem and check the box where you fit on the chart. Your doctor will then be able to recommend what type of care you need to achieve balance . . .

BALANCED NERVOUS SYSTEM

☐ High Energy ☐ Few Symptoms ☐ Resistant to Infections ☐ Positive Mental Attitude

☐ Mentally Alert ☐ Excellent Health ☐ Active ☐ Vibrant ☐

UNBALANCED NERVOUS SYSTEM

UNDER-AROUSED

- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking motivation
- ☐ Poor Concentration
- ☐ Spaciness
- ☐ Constipation
- ☐ Low pain threshold
- ☐ Difficulty waking
- ☐ Worry
- ☐ Irritable
- ☐ Low energy ☐

Low

Moderate

Severe

UNSTABLE

- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Sleepwalking
- ☐ Hot flashes
- ☐ PMS
- ☐ Food sensitivities
- ☐ Bed wetting
- ☐ Eating disorders
- ☐ Bipolar disorders
- ☐ Mood swings
- ☐ Panic attacks ☐

Low

Moderate

Severe

OVER-AROUSED

- ☐ Cold hands
- ☐ Cold feet
- ☐ Tight Muscles
- ☐ Teeth grinding
- ☐ Anxiety
- ☐ Heart palpitations
- ☐ Restless sleep
- ☐ Poor expression of emotions
- ☐ Poor immune system
- ☐ Racing mind
- ☐ High blood pressure
- ☐ Accelerated aging
- ☐ Irritable bowel ☐

EXHAUSTED NERVOUS SYSTEM

☐ Cancer ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Multiple Sclerosis ☐ Depression

☐ Chronic Fatigue Syndrome ☐ Fibromyalgia ☐ ALS ☐ Epstein-Barr Syndrome ☐

Compiled from the work By Siegfried Othmer, Susan F. Othmer, and David A. Kaiser EEG Biofeedback: A Generalized Approach to Neuroregulation

General Pain Disability Index

Name_____ Date_____

Age_____ Date of Birth_____ Occupation_____

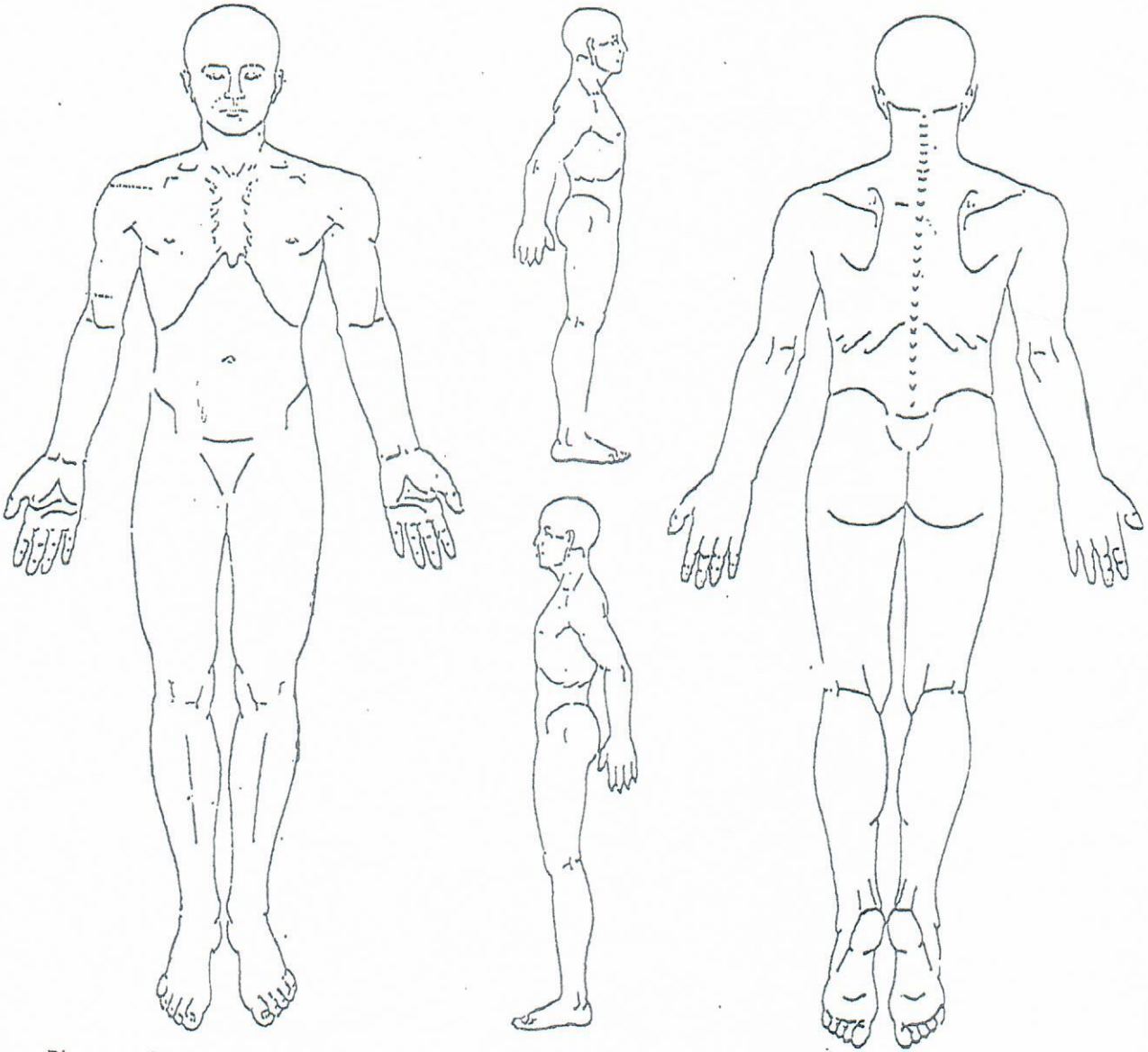
How long have you had this pain? Years_____ Months_____ Weeks_____

Is this your first Episode of this pain? Yes _____ No_____

Use the LETTERs below to indicate the type and location of your sensations RIGHT NOW

Key letters to use:

A=Ache	B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing	0=Other



Please mark on the line (using the numbers), the level of pain that most accurately represents your pain.

NO Pain 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

1. Right Now_____
2. Average Pain_____
3. At Best_____
4. At Worst_____

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work Phone ( ) _____

Email Address _____ Male_____ Female _____

Social Security # _____ Driver's Lic.# _____ Birthdate _____

Occupation/Employer's Name and address _____

Single____ Married____ Divorced____ Widowed____ Spouse's Occupation/Employer _____

No. of children:____ (In Canada) Health Card# _____ Version Code: _____

Reason for consulting our office? _____

Who may we Thank for referring you to our office? _____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

Adult - (18 to present)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do /did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Diarrhea
- ☐ Cold Sweats
- ☐ Mood swings
- ☐ Pins and needles in legs
- ☐ Loss of smell
- ☐ Buzzing in Ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck stiff
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in Ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold Hands
- ☐ Fever
- ☐ Problem Urinating
- ☐ Menstrual Irregularity
- ☐ Neck pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Stomach Upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot Flashes
- ☐ Heartburn
- ☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

• REID •
Family Wellness

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

INFORMATION ABOUT CHIROPRACTIC MANIPULATION

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment used at the Clinic is spinal manipulation therapy. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes use of the doctor's hands and mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click" such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and will be fully explained to you by your doctor after the examination has been completed and a treatment plan has been developed. Your doctor will formulate a treatment plan and will recommend what they feel is in your best interest.

THE PROBABILITY OF THOSE RICKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, your examination and while reviewing your x-rays. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed.

THE CHIROPRACTIC EXAMINATIONS

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

FINANCIAL RESPONSIBLILITY – PAYMENT & INSURANCE

Insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. We will gladly bill your insurance company as a courtesy but you are responsible for the entire bill regardless of deductible, coinsurance and copays.

MINOR PATIENTS

The adult (parent or guardian) accompanying a patient younger than 18 years of age is responsible for payment. The insured adult must be present to sign the appropriate forms. For unaccompanied minors, non-emergency treatment will be declined.

INTEREST

We reserve the right to charge interest in the amount 18%APR, as provided by state law, to all accounts that are 60(sixty) days past due. Accounts that are 120(one hundred and twenty) days past due could be turned over to our collection agency with additional charges.

Health Insurance Portability and Accountability Act

The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business Associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *"protected health information (PHI)"*. Signing this form serves as an acknowledgement of receipt of notice of privacy practices.

By signing below I state that I understand and give consent for services rendered by the doctor.

Patient/Legal Guardian Signature _____ Date _____

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