ASPEN CHIROPRACTIC & Wellness

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**WELCOME – WE ARE VERY HAPPY TO MEET YOU!**

Today's Date:_____ Is this visit the result of a work injury or auto accident? _____
Name_____ Age _____ Date of Birth _____
Parents' names (if under 18) _____
Home Address_____ City _____ State_____ Zip _____
Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Gender _____ Preferred Language _____ Race/Ethnicity _____
How were you referred to our office? _____

**CHIROPRACTIC IS NOT DESIGNED TO MAKE YOU *FEEL* BETTER; IT IS DESIGNED TO MAKE YOU *HEAL* BETTER.**

What are you goals with Aspen Chiropractic & Wellness? Enhance Health & Well-being, Optimize Performance, Pain Relief, etc.

_____

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

| | | | |
|---|---|---|---|
| ❑Work | ❑Driving | ❑Sleep | ❑Socialization |
| ❑School | ❑Walking | ❑Sitting | ❑Stress level |
| ❑Exercise/Sports | ❑Eating | ❑Relationships | Other(s): _____ |

Have you ever received chiropractic care? ❑Y ❑N Name of D.C._____ How often? _____
Date of last visit: _____Why did you stop?_____ How was your experience?_____
Who is your primary care physician? _____
Have you ever had any **imaging** (x-ray, CT, MRI, etc.) taken? Y N If yes, list when & where: _____
Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

| | | | |
|---|---|---|---|
| ❑Physical Therapist | ❑Naturopath | ❑Acupuncturist | ❑Homeopath |
| ❑Massage Therapist | ❑Psychotherapist | ❑Energy Healer | ❑Dentist |

**WOMEN ONLY**

Are you pregnant or trying? Yes/Possible/Unknown/No. Date of the start of your last period: _____ Birth Control: ❑**Y** ❑**N**
If pregnant due date? _____ Name of OBGYN or Midwife_____Location:_____
Number of pregnancies? _____ Number of natural births? _____ Number of c-sections? _____ Number of Epidurals? _____

**LET'S TALK ABOUT STRESS**

The information below will help us to see the types of **PHYSICAL**, **EMOTIONAL** and **CHEMICAL** stressors you have been subjected to and how they may relate to your present spinal, nerve and health status. Physical, emotional and chemical **STRESSES**, common to our contemporary lifestyles, can result in **DIS-EASE** of the body. The result is areas of joint restrictions causing aberrant nervous system communication, a condition sometimes called, subluxation. The chiropractic exam and treatment is specifically designed to detect areas of joint restriction and enhance proper motion thus improving function and nervous system communication.

**PHYSICAL STRESS**

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?_____

_____

Do you travel for work? ❑Y ❑N If yes, how often? _____ How long is your daily commute? _____
How many hours do you typically work in a week? _____ How many hours of T.V. do you watch in a week? _____
Please describe your physical activity program including type and frequency: _____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N Do you use a cervical pillow? ❑Y ❑N
Do you wear orthotics, heel lift, back brace, wrist brace, etc? ❑Y ❑N If yes, what kind and for how many years? _____

## PHYSICAL TRAUMAS

Have you had any other **injuries**? (Fractures, stitches, concussions, falls, sports-related, birth related, etc.) Please list dates, injury and treatment: _____

_____

_____

Please list all **surgeries**? (Include type of surgery & date of surgery.) _____

_____

_____

Have you had any **automobile accidents**?

Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: _____ Care received: _____

Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: _____ Care received: _____

## EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below (or write in others):

| | | | |
|---|---|---|---|
| ❑ Childhood trauma | ❑ Loss of loved one | ❑ Abuse | ❑ Other:_____ |
| ❑ Work or school | ❑ Divorce/separation | ❑ Financial | |
| ❑ Lifestyle change | ❑ Parents divorce | ❑ Illness | |

## CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.) Have you been **exposed** to any of the following on a regular basis, past or present? ❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑Other_____

Any recent **vaccination(s)?** ❑Y ❑N Please list:_____ Have you ever had a **reaction** to any vaccines? ❑Y ❑N

Do you have any **food allergies**? ❑Y ❑N **If yes, please list:** _____

How many **fast food meals** do you eat per week? _____ How many **alcoholic beverages** do you drink per week? _____

What is your history with **tobacco products**? ❑ Everyday ❑Occasional ❑Former ❑Never If so, how many packets per day? _____

How much **water** do you drink per day? _____ How many **caffeinated beverages** (coffee/tea/soda) per day? _____

Are you currently on **prescription** or **over-the counter medication?** ❑Y ❑N Please list, indicating dose & frequency:

_____

_____

Please list any **nutritional supplements** you are taking: _____

_____

_____

## WELLNESS

Are you interested in a further nutritional and digestive evaluation with Dr. Jess? ❑Y ❑N

How do you rate your overall **well-being** (emotional, social, physical, environmental, financial well-being)?

❑Excellent ❑Good ❑Fair ❑Poor

Do you feel you are living your **best life**? ❑Strongly Agree ❑Agree ❑Disagree ❑Strongly Disgree

**"The doctor of the future will give no medicine, but will interest his patient in the care of the human frame, in diet and in the cause and prevention of disease." –THOMAS EDISON**

*I hereby certify that the information provided is true and accurate.* Patient Signature: _____ Date: _____

**THANK YOU FOR CHOOSING ASPEN CHIRORACTIC & WELLNESS!**

## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Aspen Chiropractic & Wellness informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office. The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. We perform various ancillary procedures, such as hot or cold packs, traction, as well as exercise instruction. "In this office, we use trained staff personnel to assist the doctor with portions of your consultation, examination, therapy application, exercise instruction, etc. Occasionally, when your doctor is unavailable, another clinic doctor will treat you on that day.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligament sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the proceeding list but also include the remote possibility of cervebrovascular injury, or stroke (very rare). A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary therapy procedures could produce skin irritation, burns, or other minor complications (rare).

We do not offer to diagnose or treat any disease or condition other than joint restrictions or subluxations. 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 the disease or condition, we do not offer to treat it specifically. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate stress and interference to the expression of the body's innate wisdom. Our only method is treatment and chiropractic adjustments to restricted motion units.

Other treatment options that could be considered may include the following:
Over the counter analgesics: The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.
Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.
Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.
Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.
Concerns or Questions: Please ask your Doctor of Chiropractic. Be assured Aspen Chiropractic & Wellness has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

## NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operation will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you for up to 7 years. In the future, we may contact you for appointment reminders, missed appointments, announcements and to inform you about our practice and its staff. Our office has a semi-opening adjusting concept. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

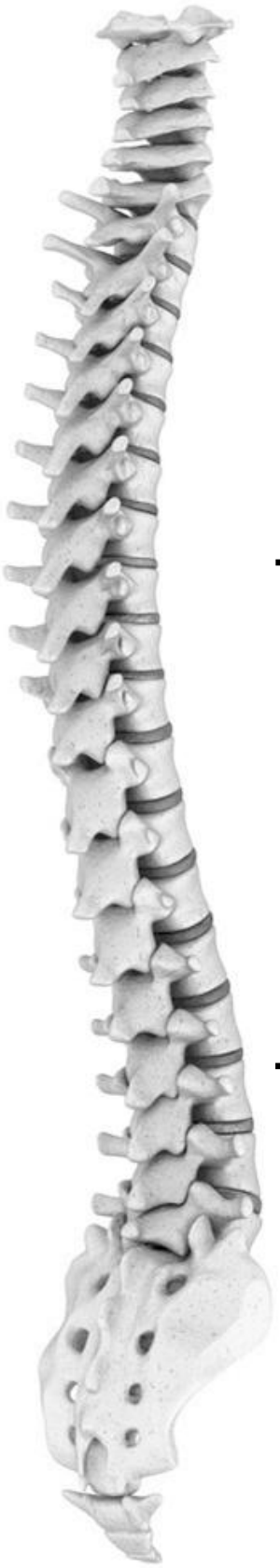
Our office participates in many community events, posted pictures on our website and is actively on Facebook. If you attended one of these events your picture maybe captured and posted. Please initial you approve of this: _____

I have read the above explanation of Chiropractic Treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

I _____ have read and understand this notice. Signature _____ Date _____

Consent to Treat Minor Children: I _____, parent or legal guardian of _____ DOB ____/____/____
Do hereby consent to any chiropractic care and administration of x-rays, comprehensive exam and/or physical therapy to be necessary for the welfare of my child while said child is under the care of Aspen Chiropractic & Wellness.
Signature of Parent or Legal Guardian _____ Date _____

**The *NERVOUS SYSTEM* controls and coordinates *ALL* organs and structures of the body!**
**Vertebrae (bones) surround and protect the nervous system consisting of brain and spinal cord.**
**Chiropractors are specialists trained in optimal FUNCTION of the body via the nervous system.**
**Please Initial that you have read. _____**



**Write 'C' for current conditions or 'P' for past conditions.**

## Cervical

- Autonomics Nervous System
- Ears, Nose & Throat
- Vision, Balance & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Sympathetic Nucleus
- Parasympathetic

| | | | |
|---|---|---|---|
| ☐ | Colic or Excessive Crying | ☐ | Epilepsy or Seizures |
| ☐ | Ear or Sinus Infections | ☐ | Sensory & Spectrum disorders |
| ☐ | Allergies or Congestion | ☐ | ADD/ADHD |
| ☐ | Immune Deficiency or Painful Joints | ☐ | Focus & Memory Issues |
| ☐ | Headaches or Migraines | ☐ | Anxiety, Stress or Emotional disorders |
| ☐ | Vertigo or Dizziness | ☐ | Balance & Coordination |
| ☐ | Sore Throat & Cough | ☐ | Speech Issues |
| ☐ | Swollen Tonsils & Adenoids | ☐ | TMJ /Jaw Pain |
| ☐ | Vision & Hearing Issues | ☐ | Stiff Neck or Shoulders |
| ☐ | Low Energy & Fatigue | ☐ | Depression |
| ☐ | Difficulty Sleeping | ☐ | High Blood Pressure or Stroke |
| ☐ | Pain Numbness & Tingling Arms-Hands | ☐ | Poor Metabolism & Weight Control |

## Thoracic

- Upper G.I.
- Respiratory
- Cardiac Function

| | | | |
|---|---|---|---|
| ☐ | Reflux / GERD | ☐ | Bronchitis or Pneumonia |
| ☐ | Chronic Colds or Cough | ☐ | Functional Heart Problems |
| ☐ | Asthma | | |

- Digestive Center
- Detox
- Immunity

| | | | |
|---|---|---|---|
| ☐ | Gallbladder Pain / Issues | ☐ | Indigestion or Heartburn |
| ☐ | Jaundice | ☐ | Stomach Pains or Ulcers |
| ☐ | Fever | ☐ | Blood Sugar Problems |

- Stress Response
- Filtration & Elimination
- Gut & Digestion
- Hormonal Control

| | | | |
|---|---|---|---|
| ☐ | Behavior Issues | ☐ | Allergies or Eczema |
| ☐ | Hyperactivity | ☐ | Skin Conditions / Rash |
| ☐ | Chronic Fatigue | ☐ | Kidney Problems |
| ☐ | Chronic Stress | ☐ | Gas Pain & Bloating |

## Lumbar, Sacrum & Pelvis

- Lower G.I. Mobility (absorption & motility)
- Gut-Immune System
- Major Hormonal Control

| | | | |
|---|---|---|---|
| ☐ | Constipation | ☐ | Sciatica or Radiating Pain |
| ☐ | Chrohn's, Colitis's or IBS | ☐ | Lumbopelvic / SI Joint Pain |
| ☐ | Diarrhea or Excessive Gas | ☐ | Hamstring Tightness |
| ☐ | Bed-wetting | ☐ | Disc Degeneration |
| ☐ | Bladder Urination Issues | ☐ | Lower Back Pain |
| ☐ | Cramps or Menstrual Issues | ☐ | Leg Weakness or Cramps |
| ☐ | Cysts or Endometriosis | ☐ | Poor Circulation or Cold Feet |
| ☐ | Infertility | ☐ | Knee, Ankle or Foot Pain |
| ☐ | Impotency | ☐ | Weak Ankles or Arches |
| ☐ | Hemorrhoids | ☐ | Gluten or Casein Intolerance |

**"Look well to the spine for the cause of disease." -Hippocrates**