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.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

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.

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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________________ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

____ ____________________________
(Signature) (Date)

Life Source Chiropractic · 15475 Ruggles St. Ste 110 · Omaha, NE 68116 · 402.934.4220
www.lifesourcechiropractic.com

Welcome To Life Source Chiropractic

First Name_______________MI ____ Last _______________________ Birth Date____/____/____ Age_____ Today's date____/____/____

Address____ City__________________________ State________ Zip_____________

Home # ( )____________________ Work # ( )____________________ Ext.__________ Soc. Sec. #_______-_______-_______

Fax # ( )________________ Beeper/Cellular # ( )________________ E-mail Address _________________________________

____ Male ____ Female # of Children ______ Single Married Significant Other Widowed Separated Divorced

Your occupation ________________________ Work duties ________________ ***WOMEN ONLY: Are you pregnant? No ____ Yes ____***

Name of Spouse (Parent if patient is under 18)_________________ Birth Date of Spouse (Parent if patient is under 18) ________________

Who may we thank for referring you to our office? _________________________ Method of payment for First Visit: *Cash Check CC*

Your Health Profile

****FOR PRESENT CONDITIONS MARK AN "X", PAST CONDITIONS MARK "O"** **(Please Circle if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers)
R / L Both

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes)
R / L Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness/ Pain	___Back Stiffness/Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Cancer
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/ Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problems
___Prostate Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness/Vertigo	___Buzzing/Ringing in ears	___Sinus Problems/Allergies	___Nervousness/Anxiety
___Fatigue	___Depression	___ Irritability/Mood Swings	___Tension/Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold feet	___Bed Wetting	___Recurring Infection	___Diarrhea/Constip./Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw/TMJ Problems
___Cold Sweats	___Light Bothers Eyes	___Problems Urinating	___Heartburn/Reflux
___High Blood pressure	___PMS	___Menopause	___Ulcers

___Other ____

Please explain if necessary:____
____

Current Health Condition

Chief Complaint (why you are her today):____
____
____

Please outline on the diagram below the area of discomfort.

When did this condition begin? ______________________________________

Has it ever occurred before: □ Yes □ No

Was this Due to an accident/Truama? If Yes, explain.(ex. fall, auto, sports,)

____

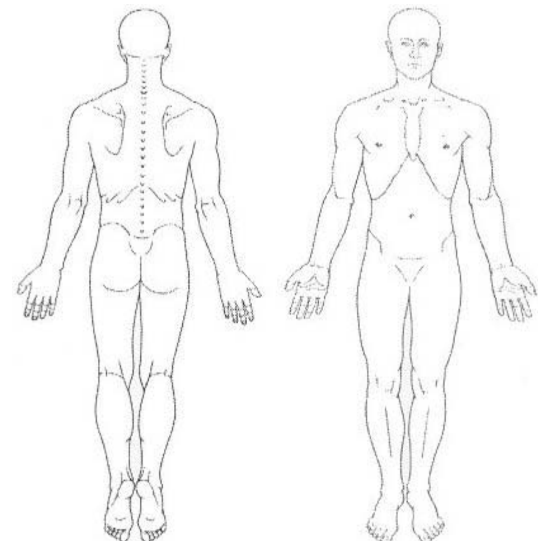
Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels?____

Severity □ Mild □ Moderate □ Severe

Does this pain travel or radiate? If so, Where?_________________________________
____

Quality: (mark all that apply)

□ Burning □ Diffuse □ Dull/Aching □ Localized
□ Sharp □ Shooting □ Stabbing □ Tingling
□ Radiating □ Other______________________________________



Is there anything that makes this better or worse?_____________________________
____

*Patient Name:*________________________________ *Date:*______________

Chief Complaint

Timing:

☐ Worse AM ☐ Worse PM ☐ Worse W/ Activity ☐ Intermittent ☐ Constant ☐ Worse at Night

How often do you find yourself suffering from this problem?______________________________________

How long does the problem last? (all the details of timing)______________________________________

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Changing Postitions	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exteded Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care – Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care – Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care – Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please List any effects that this may have on any Recreational Activities:_________________________

____

Are there any <u>other complaints/conditions</u> that the doctor should address? If so, list and describe**:**______________

____

____

____

<u>Medications:</u> What medications are you currently taking and for what conditions?

____

____

Is there anything else you think the doctor should know concerning your condition? Yes_________ No ___________

____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of the problem?_______________

Concerns that could interfere with your commitment? (Time, Transportation, Other) Specify._______________

____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

____ _____/_____/_____

Signature Date