Background And Personal Information

Name (last)____________________ (first)____________________ (mi)________

Pronouns: He/Him, She/Her, They/Them How would you like to be addressed/called?________________

Social Media Account Handles:________________________________

Home Address (street)________________________________

____

(city)________________________ (state)______(zip)__________

Home Phone (______)________________ Mobile (______)________________

Birthdate____/____/____ Age____ Email Address________________________

Employer________________________ Occupation________________________

Work Phone (______)________________ Ext.______

Male / Female (please circle biological gender) Single / Married / Partnered / Divorced / Widowed / Separated

Spouse/Partner's Name (last)____________________ (first)____________________

Employer________________________ Work Phone____________________

Number of Children____ Names and Ages________________________________

____

Emergency Contact________________________ Phone____________________

Whom may we thank for referring you to Alternative Space Chiropractic?____________________

Reason for consulting ASC?________________________________

____

____

____

How has this affected your life (family, occupation, recreation, concern for future health, etc)?________________

____

____

____

Is there anything else you would like us to know?________________________

____

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, and subtle energy rebalancing on me (or on the person named below for whom I am legally responsible) by Joshua Pickell, DC, or any Doctor of Chiropractic working with, associated with, or covering at Alternative Space Chiropractic.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, sprains, fractures, disc injury, stroke and dislocations. I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust joints and release muscles, which may cause an audible “click” or “pop” during the procedure.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________ ______________
Name (Printed) Date Signed

______________________________ ______________
Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Date Signed

______________________________ ______________
Doctor’s Signature Date Signed

There is no substitute for the chiropractic adjustment

Personal Health History (Confidential)

Name____ Date_____________________

The body is designed to be healthy. Throughout life, events and experiences can occur which may have negatively affected your body's expression of health. The following questions will help uncover potential obstacles to your body's ability to fully express health. The science of Chiropractic involves the detection and release of nerve interference and tension patterns stored throughout the body. These are caused by physical, chemical, and emotional stresses to which the body cannot adapt. Please be thorough so we can have as complete an understanding of your current state of health as possible.

Reasons for seeking chiropractic care:

To experience a new level of health and healing _____ To be more connected to my body ______

To relieve my pain ______ Not sure _____ Other (describe) ____

What is your level of commitment to yourself, your health, your wellbeing? High ________ Medium _______ Low _______

Previous Chiropractic: YES/NO If yes, date of last adjustment ______ Name of chiropractor___________________________

Reason for ending care:____

Are you currently receiving medical attention and if so, for what?____

____

Please list any medications you are currently taking (prescription and non-prescription):____________________________

____

____

Please briefly describe your daily routine, including meals, snacks, supplements, and sleep__________________________

____

____

____

What are your daily exercise habits?____

____

What are your current play/relaxation activities?____

____

How would you rate your current health? Poor Fair Average Good Excellent

How would you describe your family's health? Poor Fair Average Good Excellent

Are you healthier now than you were 5 years ago? Y / N Why?____

Do you know the health history of your birth? Y / N Home _______ Hospital _______ Natural _______ Intervention _______

What are the 5 healthiest habits you currently choose in your life?____

____

____

What are the 5 habits you would like to shift in your life?____

____

____

Many things can contribute to the Subluxation process. Below are some of the most common causes. Please check any that apply or have applied to you and indicate when if applicable.

Physical Stress	Emotional Stress	Chemical Stress
____ Birth Trauma	____ Relationships	____ Environmental
____ Slip/Fall	____ Career	____ Smoker
____ Car Accidents	____ Family	____ 2nd hand smoke
____ Sports Injuries	____ Financial	____ Caffeine
____ Physical Abuse	____ Pace of Life	____ Alcohol
____ Heavy Physical Labor	____ Quick temper	____ "Diet/sugar-free" food
____ Poor Posture	____ Holding in feelings	____ Soda intake
____ Heavy computer use	____ Perfectionism	____ Prescription drugs
____ Repetitive movements	____ Procrastination	____ Junk food
____ Prolonged driving/standing	____ Depression	____ Recreational drugs

What do you feel is the primary stress in your life?____

Why is your health important to you (how will your life be better and what will you do once you reach your health goals)?

____

____

In our office we are not only interested in your health and wellbeing but also in the health and wellbeing of your family and loved ones. Current research indicated that family health patterns often emerge throughout life that can offer useful information about the health of individuals. Please mention any health conditions or concerns you may have about your

Spouse/partner:

Children:

Parents (include significant medical history):

Siblings:

Financial Information: Who is responsible for this account with Alternative Space Chiropractic?________________________

Joshua Pickell DC does not offer to diagnose or treat any symptom or disease condition. Our sole purpose is to analyze your system for Subluxation patterns and to help your body release them so it can more fully express its innate ability to heal. Wellness is a dynamic equilibrium between health and disease. It exists when all organs of the body function at 100% under the direction of the nerve system and the Innate Intelligence of the body. If during your assessment a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider to serve you.

I, ____________________________ , have answered the above questions to the best of my knowledge. Based on the information provided, I grant Joshua Pickell, DC permission to assess, locate, and release my subluxation patterns.

Your signature ____ **Date**_______________________

Terms of Acceptance / Philosophical Agreement

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

- There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
- The Nervous System is the main coordinating and distribution system for the body's innate intelligence.
- Alterations or distortion in the shape, position, tone, or tension of the Nervous System, especially in the spine, will interfere with the expression of this intelligence.
- Chiropractors call this interference to the proper functioning of the Nervous System a Subluxation. Subluxation alters nerve function and distorts the communication channels between the brain and the body. This results in a decrease of the body's innate ability to express its maximum health potential.
- Health is a state of optimal physical, mental/emotional, and spiritual/social well-being, and is not merely the absence of disease, symptoms, or infirmity.
- Symptoms are not necessarily a sign of illness, but also occur to alert the individual of the need for change. Specific locations of symptoms do not tell the specific location of subluxations, and the severity of symptoms is not directly related to the severity of subluxations.
- An Adjustment is the specific and honoring application of forces to facilitate the body's release and integration of subluxation. The adjustment takes many forms and looks different for each specific subluxation.
- The sole purpose of the chiropractic adjustment in this office is to assist your body in releasing subluxations so it may benefit from the restoration of clear communication channels in the body. Everyone, regardless of their symptoms or ailments, will benefit from a nervous system which is more flexible, elastic, and free of subluxation.
- We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body's innate wisdom and to support your body to hold and integrate adjustments. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.
- I understand that the purpose of the adjustment is to allow the internal wisdom of the body to fully express itself. Drugs, such as tranquilizers, muscle relaxers, anti-inflammatory compounds, beta blockers, many anti-hypertensive drugs, and pain blocking medications by their very intent interfere with the functioning of the nervous system. Electrical stimulation, ultrasound, and traction, also interfere with adjustments. I will not venture into the practice of medicine by telling you to take or not to take any specific treatment. I feel it is your responsibility to speak with your physician to determine the objective to be obtained by ingesting any drug or receiving any treatment and to determine if this is consistent with your desire for wellness. You should seek a physician's consult in potential reductions of medication levels. As adjustments help a body normalize, the body chemistry changes. Naturally, medication levels for a non-flexible body, stuck in dis-ease, is not the same as recommended for a body in the process of healing.

I,_______________________________________, have read the above statements and understand the doctor's objectives pertaining to my care in this office. I accept chiropractic care on this basis.

Signature Date

Consent to evaluate and adjust a minor/child:

I,____________________, being the parent or legal guardian of ___________________________, have read and fully understand the above terms and acceptance and hereby grant permission for my child to receive chiropractic care in this office.

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Alternative Space Chiropractic's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for ASC to provide treatment to me, and necessary for ASC to obtain payment for that treatment and to carry out its health care operations. ASC explained to me that the Privacy Notice will be available to me in the future at my request. ASC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.

2. ASC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following communications that will be used by ASC: a) calling and leaving voice messages on my phone or with the individual answering the phone, b) text messaging to my mobile phone, c) messages, tags, comments, likes, or other interactions on social media accounts provided by me, d) a card, letter, or other written information mailed to me at the address provided by me; e) sending an electronic mail to the address provided by me.

4. ASC may use and/or disclose my PHI in order for ASC to treat me and obtain payment for that treatment, and as necessary for ASC to conduct its specific health care operations.

5. I understand that I have a right to request that ASC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, ASC is not required to agree to any restrictions that I have requested. If ASC agrees to requested restrictions, then the restriction is binding on ASC. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the ASC has already taken action in the reliance on this consent.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the ASC has already taken action in the reliance on this consent.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, ASC will not treat me. I further understand that if I revoke this consent, at any time, ASC has the right to refuse to treat me.

8. ASC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in ASC's practice.

I acknowledge that I have received a copy of ASC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

____ ____________________

Patients 's Name (printed) Date Signed

____

Signature (patient or legal representative)