YOUR WELLNESS BEGINNING

the first step in care

WE'RE SO GLAD YOU'RE HERE. PLEASE COMPLETE ALL REQUESTED INFORMATION.

Full Name: _____ Birthdate: _____

Address/City/State/Zip:

_____

Phone: _____ Are you okay with text message reminders ? ☐ Yes ☐ No

Email: _____ Marital Status: M / S / D

Children's Name & Ages: _____

Occupation: _____

Favorite Hobbies or Interests: _____

How did you hear about us? _____

Have you had chiropractic care before? ☐ Yes ☐ No

If yes, what was your experience like & how long ago was it?

_____

What's been going on that led you here?

☐ Stiffness/ Discomfort ☐ Headaches/ Migraines ☐ Poor Sleep ☐ Brain Fog/ Fatigue ☐ Digestive Issues

Other: _____

Is your visit related to a work injury or a car accident? ☐ Yes ☐ No

How long has this been occurring?

_____

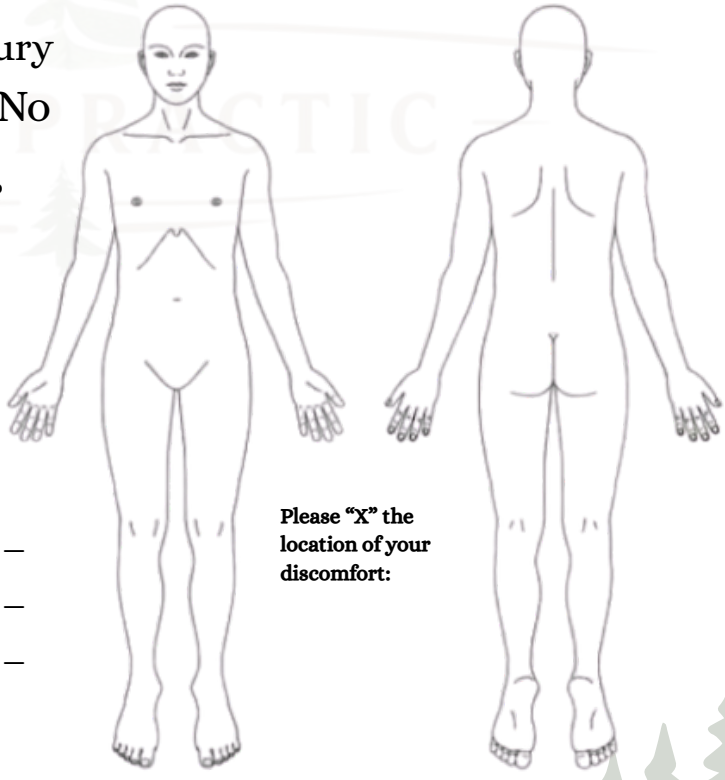
_____

Is there anything else you'd like to share so we can best support your care?

_____

_____

_____



Please "X" the location of your discomfort:

GETTING TO KNOW YOUR HEALTH

Everything your body goes through can leave noticeable & sometimes subtle effects.
Please take a moment to answer the following questions thoroughly so we can best support you.

Is there any chance that you are pregnant? ☐ YES ☐ NO

Have you ever had any significant injury's or accidents?
If yes, please explain: (Even if it was years ago)

_____

_____

Please list previous surgeries:

_____

_____

_____

Please list medications/supplements you're currently taking:

_____

_____

Have you ever been diagnosed with cancer? ☐ YES ☐ NO

If so, what type & when:

_____

_____

Do you drink alcohol? ☐ YES ☐ NO
Daily or Socially:_____

Do you smoke? ☐ YES ☐ NO
Amount Per Day:_____

How are your sleeping habits? (circle all that apply) Average Hours:___

Stomach Side Back Restless Restorative Use CPAP

How would you describe your energy levels? ☐ Low ☐ Good ☐ Great

What does your caffeine intake look like? ☐ N/A ☐ Low ☐ High

Are you drinking half your weight in ounces of water? ☐ YES ☐ NO

Do you experience frequent headaches? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE HOW OFTEN AND HOW INTENSE:

_____

How often do you exercise? ☐ N/A ☐ Low ☐ Moderate ☐ High
WHAT'S YOUR WORKOUT ROUTINE LOOK LIKE?

_____

How does this problem impact your daily activities at its worst?

_____

_____

Patient or Guardian Signature :

_____

GROWING TORWARD WELLNESS

Where your goals take root

What does Chiropractic care mean to you?

_ _

_ _

What are your hopes or expectations for care?

THIS CAN INCLUDE GOALS, CHANGES YOU'RE HOPING TO NOTICE, OR SUPPORT YOU'RE LOOKING FOR!

_ _

_ _

Growing healthy together...

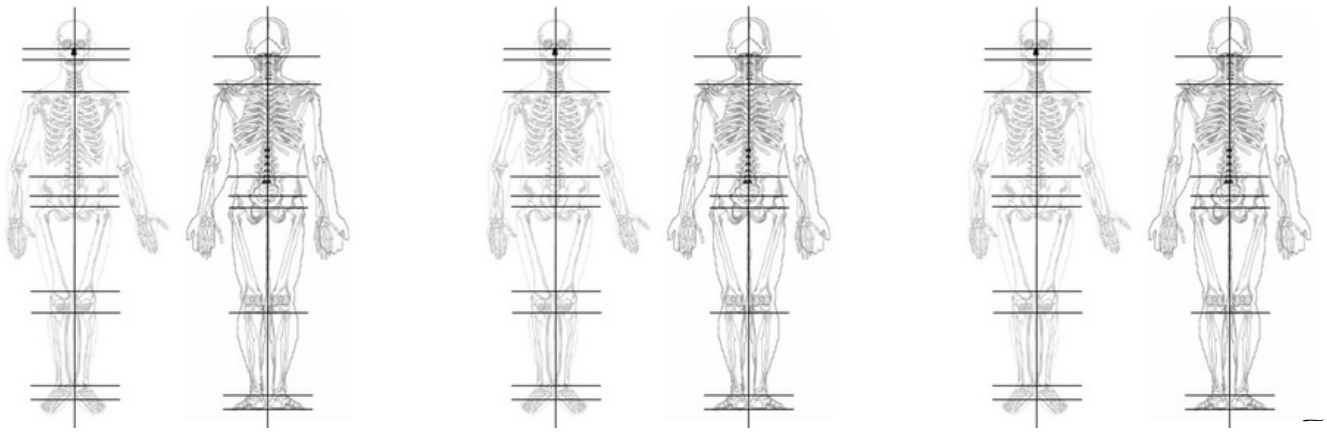
Posture is a window into the health of your spine, and one day it will be widely understood that the way we stand and move reflects our overall well-being. Subtle postural changes, such as a head that sits forward, a shoulder that sits higher, or hips that are uneven can be signs of stress within the spine that may place pressure on the nervous system and affect optimal function.

To check the posture of someone you love at home, have them stand with feet shoulder-width apart, gently nod their head, then close their eyes and relax. Notice if the head shifts, or if one shoulder or hip sits higher than the other. Mark on the image below where you see any postural imbalances. Even small imbalances can offer important insight into spinal health.

14 DAYS TO NURTURE

When a loved one is ready to begin their journey to wellness, simply having them mention this 14-day care window when they book their appointment ensures their exam will be on us. They don't need to be seen right away, just a simple mention at scheduling is all it takes.

Excludes Medicare and Medicaid



INIT.

_____

OUR WAY OF BEING

less about rules and more about staying connected and creating space where healing can truly happen.

NEW PATIENT POLICIES:

We are committed to giving you our highest level of care. To support that commitment, all patients are welcomed with an understanding of the following office policies.

INIT. ___

PREFERRED HOURS:

We strive to make your visits both efficient and meaningful. Designated adjustment hours help keep your time in the office flowing smoothly, and during your preferred patient hour (right now) our attention is fully dedicated to you. If you have specific questions or concerns for the doctor during a regular adjusting hour, please let us know ahead of time so we can give you the attention and care you need.

INIT. ___

SCHEDULING:

To support steady progress in your care, we encourage scheduling appointments ahead of time and limiting frequent changes. If a change is needed, we ask that your visit be made up within the same week so your care stays on track.

INIT. ___

MISSED APPOINTMENTS:

We understand that schedules can change and rescheduling may sometimes be necessary. However, missed appointments without notice make it difficult for us to provide consistent care which is crucial in consistent progress and why we ask you to schedule within the same week. We kindly ask that you notify us if you are unable to attend your appointment. *Repeated no call/no show appointments may unfortunately result in dismissal from care.*

INIT. ___

Our mission is to restore and protect the expression of the body's innate wisdom. Through specific chiropractic adjustments, home care strategies, lifestyle optimization, and nutritional support, we address the physical, chemical, emotional, and spiritual stressors that contribute to vertebral subluxations.

In Case of Emergency Contact:

Name: _____ Phone: _____

Relation:_____

Method of Payment For Visits:

Cash / Check / Card / HSA or FSA

Signature:_____ Date:_____

WELLNESS AGREEMENT

Successful outcomes rely on a mutual understanding of the care objectives, ensuring that the patient and practitioner are working collaboratively toward the same health and wellness milestones.

Chiropractic Care: Focuses on correcting spinal misalignments that can interfere with the body's natural ability to heal and function at its best. We believe it is important for every patient to understand both the goal of care and the process used to achieve it, allowing us to move forward together with clarity, confidence, and shared expectations.

Adjustment: An adjustment is a precise and controlled movement applied to the spine to help restore proper motion and alignment. This helps the body function more naturally and efficiently. Our chiropractic care focuses on specific spinal adjustments designed for each patient.

Vertabral Subluxation: A vertebral subluxation occurs when one or more of the 24 bones of the spine lose their normal position or motion. These changes can create tension or interference within the nervous system, which may impact how the body moves, heals, and adapts to daily stress.

Re-Exam: These are completed about every 8–10 visits to review your progress and evaluate how your body is responding to care. Decisions regarding ongoing treatment are made based on these findings.* *For patient safety and quality of care, a re-exam is also required if more than 30 days have passed since your last visit.**

X-rays: X-rays may be utilized as a diagnostic tool to help identify the precise location of spinal misalignments and to evaluate for any conditions that may contraindicate chiropractic care. The decision to order X-rays is made at the doctor's clinical discretion.

Spinal Workshops: We offer educational workshops on various health-related topics. These are typically held Tuesday evenings from 6:30–7:00 pm. These classes are designed to help patients improve recovery, maintain results longer, and become more proactive in their health.

If we notice something that isn't chiropractic in nature, we'll guide you to the right healthcare professional for further evaluation.

All questions regarding the doctor's objectives and my care in this office have been answered to my satisfaction. I understand and accept chiropractic care under these terms.

Patient Signature: _____

Date: ____ / ____ / _____

Witness: _____

FUNCTIONAL RATING INDEX

To better understand your condition and how to help you, we want to know how any physical discomfort or movement challenges are affecting your day-to-day life and routine activities.

Please circle which best describes your discomfort level

1. **Pain Intensity:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

2. **Sleeping:**

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. **Personal Care:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Severe Pain W/ Assistant

4. **Travel** (driving):

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Severe Pain (short trips)

5. **Work:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Severe Pain (not working)

6. **Recreation:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Not able to do activity

7. **Frequency of Pain:**

0	1	2	3	4
No Pain	25% of the day	50% of the day	75% of the day	100% of the day

8. **Lifting:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Not able to increase weight

9. **Walking:**

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Only able to walk short distance

10. **Standing:**

0	1	2	3	4
No Pain	Mild Pain	Pain after an hour	Pain after 30 minutes	Pain with any standing

Signature: _____ Date:_____