



## 7 – YOUR HEALTH PROFILE

### Why This Form is Important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. We are interested in what may have caused your problem in addition to what symptoms are actually affecting you now. Our mission is to help you achieve your health goals...whether that be recovery from a specific ailment or life long health and wellness. On a daily basis we experience mental, physical and chemical stresses that can accumulate and result in loss of health potential. Answering the following questions will give us a profile of specific factors in your life that may be contributing to less than optimal health.

We are honored to serve you and look forward to assisting you fulfill your inborn health potential.

a. Please rate your overall health status: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

b. What are your health goals? \_\_\_\_\_  
 \_\_\_\_\_

c. Are you healthier today than you were 5 years ago? Yes No

d. Have you had previous chiropractic care? Yes No If yes, when was your last visit? \_\_\_\_\_

e. Were you aware that:

- Doctors of Chiropractic have more classroom hours of education than medical doctors and go to school a minimum of 6 years? Yes No
- Chiropractors work with the nervous system? Yes No
- The nervous system controls and coordinates all functions and systems of the body? Yes No
- Chiropractic is the largest natural health care profession in the world? Yes No
- Children, even during birth, may develop imbalances/ misalignments in their spine and that studies have shown kids who get regular chiropractic care have fewer ear infections, less colic, receive fewer prescriptions, experience fewer colds and are overall healthier? Yes No

f. Have you ever had a doctor that you felt really understood your problem, listened to you and your needs, explained their analysis in a way you could understand and that made sense, and truly cared about you as a person? Yes No

## 8 – MEDICAL HISTORY

Please list the cause of death and age of any immediate family members (parents or siblings):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please circle any of the following illnesses/ conditions you have had:

Pneumonia	Mumps	Influenza
Small pox	Pleurisy	Polio
Chicken pox	Arthritis	Tuberculosis
Diabetes	Epilepsy	Cancer
Anemia	Heart disease	Measles
Thyroid disorder	Eczema	Concussion
Depression	Meningitis	High cholesterol
Rheumatic fever	Whooping cough	High blood pressure

Surgeries

Date and Reason

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Previous Traumas (include date and description)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Pregnancies (include year and outcome):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are you pregnant? Yes No Not sure

## 9 – CURRENT HEALTH CONDITIONS

List up 3 complaints below and answer the following questions regarding each. List your primary complaint as #1.

<b>List your complaint(s) here:</b>	1. _____	2. _____	3. _____
a. When did you first experience this problem?	_____	_____	_____
b. How did this problem first begin?	_____ _____ _____	_____ _____ _____	_____ _____ _____
c. How often do you experience this problem?	_____	_____	_____
d. Rate intensity of this problem: (1 = mild; 10 = extreme)			
- At its best	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
- At its worst	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
e. Describe how it feels (eg aching, burning, stabbing, sharp, etc.):	_____ _____	_____ _____	_____ _____
f. Describe the location of pain:	_____ _____	_____ _____	_____ _____
g. What makes it better?	_____ _____	_____ _____	_____ _____
h. What makes it worse?	_____ _____	_____ _____	_____ _____
i. Does the pain radiate to other areas? If yes, explain where.	_____	_____	_____
j. Is this problem getting better, worse or staying the same?	better worse same	better worse same	better worse same
k. What time of day does this problem affect you the most?	_____	_____	_____
l. What have you tried to do to relieve this problem? (previous treatments)	_____ _____	_____ _____	_____ _____
m. Have you seen other doctors for this problem (if yes, list)?	_____	_____	_____

List any known allergies: \_\_\_\_\_

Have you ever been tested for food allergies? no yes (if yes, list) \_\_\_\_\_

## 10 – LIFESTYLE AND SOCIAL HISTORY

Job Description: \_\_\_\_\_

Work Hours per week \_\_\_\_ Occupational Stress Level (1-10) \_\_\_\_ Personal Stress Level (1-10) \_\_\_\_

Recreational Activities: \_\_\_\_\_

Circle all that apply: smoke cigarettes – drink alcohol – drink coffee – exercise regularly – get enough sleep

## 11 – RECENT MEDICAL HISTORY

Please check any of the following you have had in the past 6 months:

### MUSCULOSKELETAL

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/ stiffness
- Walking problems
- Difficulty chewing/ clicking jaw
- Hand pain
- Elbow pain
- Hip pain
- Knee pain
- Foot/ ankle pain

### NERVOUS SYSTEM

- Numbness
- Anxiety
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Fainting
- Depression
- Convulsions
- Seizure
- Tingling extremities
- Disturbed/ poor sleep

### GENITOURINARY

- Bladder trouble/ infection
- Painful urination
- Excessive urination
- Discolored

### GASTROINTESTINAL

- Poor/ excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gallbladder problems
- Weight trouble
- Abdominal cramps
- Gas/ bloating after meals
- Heartburn
- Black/ bloody stools
- Colitis
- Irritable bowel
- Non-formed (loose) stool

### GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

### EYES, EARS, NOSE, THROAT

- Vision problems
- Dental problems
- Hearing loss
- Sore throat
- Ear aches
- Stuffy nose
- Sinus infections

### HEART AND LUNGS

- Chest pain
- Shortness of breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems/ congestion
- Varicose veins
- Ankle swelling
- Stroke
- Blocked/ clogged arteries
- High cholesterol

### FEMALE

- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/ infection
- History of breast cancer
- Breast pain/ lumps
- Yeast infections
- Infertility/ trouble conceiving
- Other: \_\_\_\_\_

### MALE

- Prostate
- Sexual dysfunction
- Difficulty with urination
- Other: \_\_\_\_\_

## 12 – HEALTH OBJECTIVES

Please identify your health objectives (check all that apply):

- I would like to find out what is causing my problem(s).
- I am interested in learning what I can do to help correct and prevent future problems from developing.
- I would like a Health Development Program designed for me (no extra charge) ... this is a step by step plan to help you regain and maintain optimal health.

Thank you for the opportunity to assist you in your recovery and/ or maintenance of optimal health and we look forward to helping you live a healthier life, naturally!

Dr. Rob Berube and Staff



## **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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:**

The 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 and/or extremities

**Health:**

The state of optimal physical, mental and social well-being, and 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 diagnoses of or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination 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 another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations or subluxation of the extremities. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

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

Therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**Consent to evaluate and adjust a minor child (check, fill, and sign below)**

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

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. \_\_\_\_\_

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# Naturally Right.....Chiropractic Care

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. I understand and agree to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations (**TPO**), and coordination of care. I understand that I can refer to The Creating Wellness Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.
2. I understand I have the right to examine and obtain a copy of my own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. With this consent, The Creating Wellness Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. With my consent, The Creating Wellness Center may mail or email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. I have the right to provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. By signing this form, I am consenting to The Creating Wellness Center's use and disclosure of my PHI to carry out TPO.

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Name of Patient

Date

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Signature of Patient or Legal Guardian

# Fee Schedule

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## Examination

<b>\$60</b>	Insight Scans	<i>Consultation, Exam, and Report of Findings Workshop</i>
<b>\$190</b>	4 Scan Package	<i>(Save \$50)</i>
<b>\$75</b>	X-rays	
<b>\$60</b>	Wellness Assessment	<i>Consultation, Exam, and Report of Findings</i>
<b>\$50</b>	Additional Report of Findings	

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## Adjustments (Non-Third Party Reimbursement)

<b>\$45</b>	Individual	
<b>\$70</b>	Couple	<i>(Save \$20)</i>
<b>\$90</b>	You Plus Two	<i>(Save \$45 for family of 3)</i>

*Couple and Family Per-Visit Discounts apply when immediate family members receive care together and where all dependent family members reside within the same household.*

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## Individual Adjustment Packages (Non-Third Party Reimbursement)

<b><u>Family</u></b>	<b><u>150</u></b> Adjustments	<b>\$4020</b>	<i>(Save \$2730)</i>
	<i>*Ideal for Families up to 4 people. Monthly payments available for \$335.00 per month.</i>		
<b><u>Platinum</u></b>	<b><u>50</u></b> Adjustments	<b>\$1850</b>	<i>(Save \$400)</i>
	<i>*Ideal for Weekly Check-ups– Best Value. Monthly payments available for \$154.17 per month.</i>		
<b><u>Gold</u></b>	<b><u>25</u></b> Adjustments	<b>\$1000</b>	<i>(Save \$125)</i>
	<i>*Ideal for Bi-monthly Check-ups. Monthly payments available for \$166.67 per month.</i>		
<b><u>Silver</u></b>	<b><u>12</u></b> Adjustments	<b>\$500</b>	<i>(Save \$40)</i>
	<i>*Ideal for Monthly Check-ups.</i>		

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**Monthly Payments Available:** *You may be eligible to finance your care at 0% interest for the term of your care plan. Ask our front desk for more specific information about making monthly payments toward our care packages.*

**Discontinue Policy on Packages:** *All services will be tallied according to our standard \$45 adjustment. If you have received less care than the amount paid, you will receive a refund.*

## How can I utilize my Insurance at this office?

If you have insurance that covers active treatment chiropractic care, we will submit all of the information to get reimbursed from your insurance company and we will accept assignment in most cases. This includes your diagnosis and treatment records. If you choose to submit your own claims, we will provide receipts for your initial exam and then once per month afterward. You need only send in your receipts with your insurance company's claim form and your insurance company will communicate directly with you regarding your reimbursement. Remember, your agreement with your insurance company is a contract between you and them.

## How are Medicare and Supplemental Insurance handled in this office?

This office files Medicare and Supplemental insurance claims. Medicare typically covers 80% of 12-30 Active Care Spinal Adjustments per calendar year. Your Supplemental Insurance Policy may pay the remaining 20% if it covers Chiropractic care. Medicare and Supplemental Policies will NOT cover Examinations, X-rays performed in this office or Maintenance Chiropractic care. If there is no Supplemental insurance, the 20% not paid by Medicare will be your responsibility. After your covered Active Treatment is completed, you will be eligible for our non-covered Maintenance/Wellness care plans.

## What if I have been injured in an auto accident or on the job?

If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular by-the-visit office fees until such claim is settled. Once a settlement has been made, you will then be eligible for our regular care plans.