WELCOME TO OUR CLINIC! We specialize in assisting our patients to achieve their highest level of health through our specific and analytical approach using the **Gonstead Method of Chiropractic**. Our approach is unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you!

First Name______________________Middle_____Last_______________________ Today's Date ___/___/___

Age_______ Male/Female Date of Birth ____/____/________

Address________________________________ City________________________ State______ ZIP __________

Phone: Home _____________________ Cell________________________ Preferred number _______________

Email Address ____

Occupation___________________ Employer's Name ___________________ Are you a student? Y / N

Single / Married / Widowed Spouse's Name ____________________ # Children ____________

Names, Ages, & Genders

____

Who may we thank for referring you into our practice? ____

PLEASE LIST YOUR HEALTH CONCERNS BELOW IN ORDER OF SEVERITY

	Concern	Severity 1-10	Start Date	Prior Concern?	From Injury?	Constant/ Intermittent
1.	______________________	_____	__________	_____________	____________	______________________
2.	______________________	_____	__________	_____________	____________	______________________
3.	______________________	_____	__________	_____________	____________	______________________

What is this affecting that is **MOST** important in your life? (List all that apply)

____

List **three** goals and expectations that you hope to achieve through your chiropractic care:

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: ____

Have you ever seen any other doctor for this condition? ____Chiropractor ____ Medical Doctor ____ Other

If so, WHO & WHEN ____

List Surgeries & Date ____

____

List all MEDICATIONS you are currently taking ____

____

Have you had previous chiropractic care? Y / N If YES, when & who? ___________________________

When was your last auto accident? ____________ Have you ever been knocked unconscious? Y / N

Have you fractured any bones? Y / N If YES, please describe _______________________________

Other traumas? Please describe ____

CIRCLE ANY OF THESE CONCERNS THAT YOU HAVE HAD IN THE PAST 2 YEARS

DIZZINESS	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES	ULCERS	BLADDER PROBLEMS	LUPUS
VERTIGO	CHEST PAINS	IRRITABLE BLADDER	FIBROMYALGIA
EAR INFECTIONS	ARMS NUMBNESS	SCIATICA	ADD/ADHD
GRATING OF NECK	ARM PAIN	LEG NUMBNESS	GERD
TMJ	HAND NUMBNESS	FEET NUMBNESS	ANXIETY
NECK PAIN	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
MIGRAINES	HEART DISORDERS	HIP PAIN	EPILEPSY
STIFF NECK	MID BACK PAIN	LEG PAINS	DISC PROBLEMS
CHRONIC SINUS	INFERTILITY	STOMACH DISORDERS	KNEE PAIN
THROAT ISSUES	NAUSEA	LIVER DISEASE	HIGH BLOOD PRESSURE
THYROID ISSUES	REFLUX	MENSTRUAL ISSUES	OTHER________________

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:
STROKE-CANCER--SPINAL SURGERY OR FRACTURE-SEIZURES-SCOLIOSIS-DIABETES

Your Physical Life

Presence of physical pain	1 2 3 4 5	Incidence of colds or flu	1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility	1 2 3 4 5	Ability to work out or engage in activity	1 2 3 4 5
Incidence of fatigue or low energy	1 2 3 4 5	Incidence of chronic disease	1 2 3 4 5

Mental/Emotional State

Presence of negative feelings/energy	1 2 3 4 5	Being overly worried about small things	1 2 3 4 5
Moodiness, temper, or angry outbursts	1 2 3 4 5	Difficulty thinking or concentrating	1 2 3 4 5
Difficulty falling or staying asleep	1 2 3 4 5	Feeling of depression or anxiety	1 2 3 4 5

Chemical/Nutritional Life

Eat a well-balanced diet	1 2 3 4 5	Eat organic, grass fed, hormone free	1 2 3 4 5
Eat a diet rich in fruits and vegetables	1 2 3 4 5	Use a lot of chemicals on your skin	1 2 3 4 5
Eat fast food or highly processed food	1 2 3 4 5	Ingestion of chemicals	1 2 3 4 5

Stress Evaluation

Family	1 2 3 4 5	Work/school	1 2 3 4 5
Significant relationship	1 2 3 4 5	Day-to-day stress	1 2 3 4 5
Health	1 2 3 4 5	Finances	1 2 3 4 5

Life Enjoyment

Experiences of relaxation, ease, or well-being	1 2 3 4 5	Compassion and acceptance	1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet etc.	1 2 3 4 5	The level of recreation in your life	1 2 3 4 5
Time devoted to things you enjoy	1 2 3 4 5	Your physical appearance	1 2 3 4 5

HEALTH STATUS QUESTIONARE

Rate based on a frequency scale of 1-5.

(1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly)

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. The disc will be available within 72 hours of prepayment on any regular practice hours/days. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Nordik Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above Terms and Conditions. I hereby grant Nordik Chiropractic, LLC permission to perform an x-ray evaluation of my spine and/or extremities. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature____ Date ___________ (If under age 18, Parent's signature)

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT NORDIK CHIROPRACTIC.

Signature ____ Date ___________ (If under age 18, Parent's signature)

SELF PAYMENT POLICY

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. Nordik Chiropractic does not bill to any insurance companies, including, but not limited to Medicare, Medicaid, or Motor Vehicle Insurances. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

By signing below, you confirm that you have been advised Nordik Chiropractic is a **NON PARTICIPATING** provider with Medicare. We do not submit or process claims from the office, nor have the software capability to prepare superbills. Wellness services that are provided in our office are on a self-pay basis only, and Medicare will NOT reimburse you for payments made to the Nordik Chiropractic clinic if you choose to appeal. Please address any additional questions or concerns with our office staff prior to your initial exam.

Signature ____ Date ___________ (If under age 18, Parent's signature)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. OUR OFFICE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND PARTICULARLY, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

I do hereby authorize the doctor(s) of Nordik Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. Furthermore, I authorize and agree to allow the doctor(s) of chiropractic at Nordik Chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic. I have had an opportunity to discuss with the doctor of chiropractic at Nordik Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care**.**

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic. I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered. In the event that it is necessary to retain an attorney, the prevailing party shall be entitled to recovery of attorney's fees and costs. I, ______________________________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Print Name ____

Signature ____ Date ______________ (If under age 18, Parent's signature)

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:
A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.
By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic facility, we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 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 a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Nordik Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Signature____ Date ___________ (If under age 18, Parent's signature)

CONSENT TO EVALUATE AND ADJUST A <u>MINOR</u> AND ACKNOWLEDGEMENT OF BEHAVIOR POLICY

(If applicable) I, ____ being the parent of legal guardian of

______________________________________ have read and fully understand the above terms of acceptance and hereby

grant permission for my child to receive chiropractic care.

I do hereby acknowledge that as a patient or as a guardian of a patient who is a minor am responsible for being considerate of the needs of other patients and members of the staff. I understand that all minors must be accompanied by an adult at all times. I further understand that any disruptions caused by myself or any other person that I bring to the premises may be a cause for the staff to remove such persons from the premises.

Signature of Parent/Guardian ____ Date ________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature ____ Date ______________ (If under age 18, Parents signature)

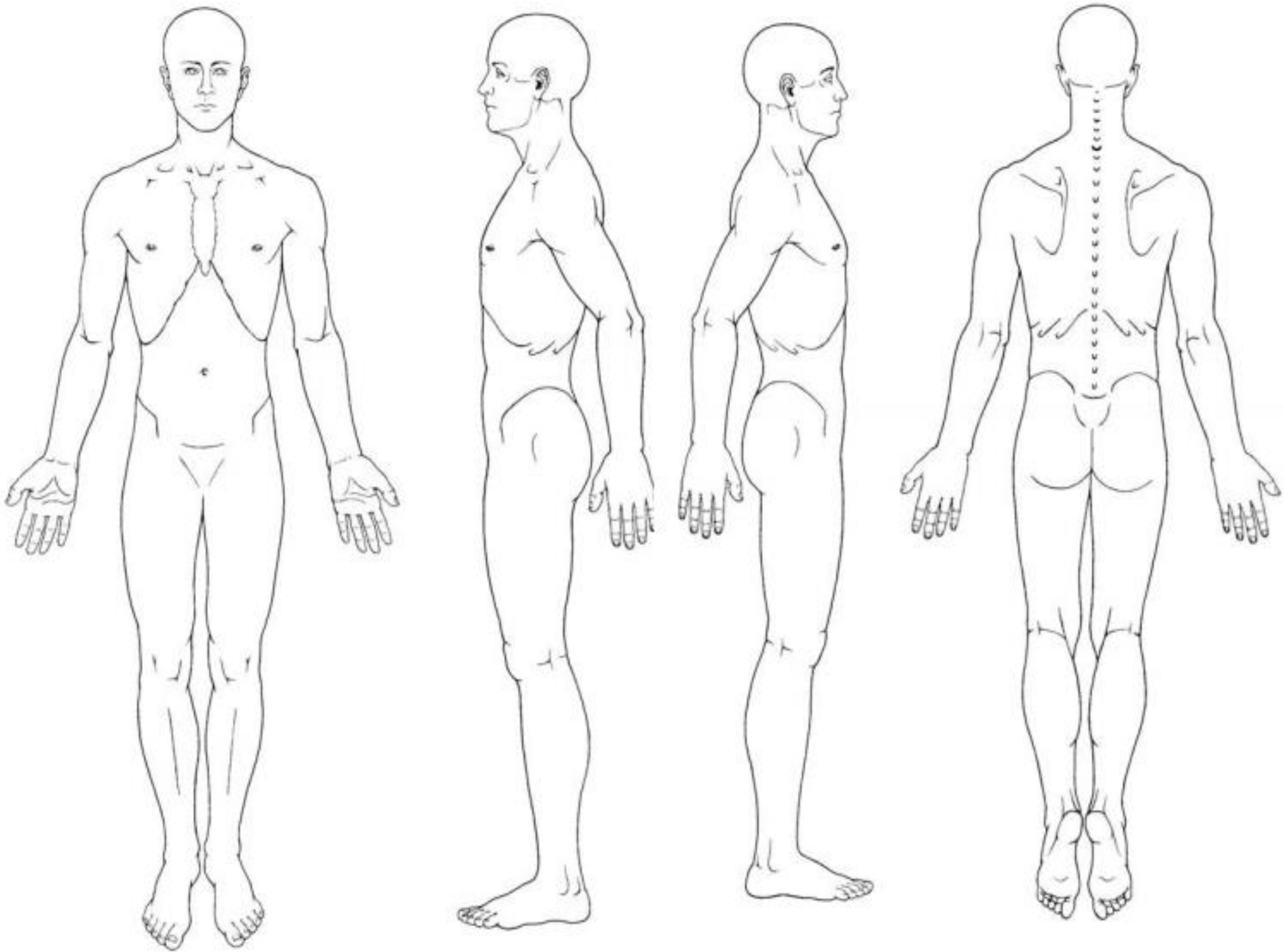
24 HOUR APPOINTMENT CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, Nordik Chiropractic has a 24-hour cancellation / rescheduling policy. The policy enables us to better utilize available appointments for our patients in need of health care. We understand that sometimes you need to cancel or reschedule your appointments and there are emergencies. This policy is in place out of respect for the Doctor, and our clients. Please be courteous and kindly call the clinic at least 24 hours prior if you are unable to attend an appointment so that someone else urgently needing a treatment can be seen at that time. You may not cancel via email/ text. There is no charge if your appointment is canceled 24 hours in advance. Appointments missed or canceled without 24-hour notification will be charged a Missed Appointment Fee of $20. Our clinic in turn will do our best to minimize your waiting time. If your schedule is hectic or you are NOT sure if you can keep your appointment, then you can schedule it on the day of treatment (if availability permits)

Signature ____ Date ______________ (If under age 18, Parents signature)

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.