

## About You (the Practice Member)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Gender  M  F Number of Children \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Marital Status  Married  Single  Divorced  
 Separated  Widowed

Would you like to receive newsletters?  Yes  No

Email Address \_\_\_\_\_

The best way to contact you: Home/Cell/Work

For appointment reminders, is it ok to text your cell phone?  Yes  No Who is your carrier? \_\_\_\_\_

## Reason For This Visit

Describe the purpose of this visit: \_\_\_\_\_

## Medications I Now Take

- |  |   |
|--|---|
| <input type="checkbox"/> Nerve Pills                       | <input type="checkbox"/> Stimulants     |
| <input type="checkbox"/> Pain Killers (including Aspirins) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers                   | <input type="checkbox"/> Tranquilizers  |
| <input type="checkbox"/> Blood Pressure Medicine           | <input type="checkbox"/> _____          |
| <input type="checkbox"/> Insulin                           | <input type="checkbox"/> _____          |

## Health Habits

- |                            | No  | Yes                      |
|----------------------------|---|--------------------------|
| Do you smoke?              | <input type="checkbox"/>  | <input type="checkbox"/> |
| Do you drink alcohol?      | <input type="checkbox"/>  | <input type="checkbox"/> |
| Do you drink coffee?       | <input type="checkbox"/>  | <input type="checkbox"/> |
| Do you exercise regularly? | <input type="checkbox"/> No <input type="checkbox"/> Moderate               |                          |
|                            | <input type="checkbox"/> Daily  |                          |
| Do you wear                | <input type="checkbox"/> Heel Lifts <input type="checkbox"/> Sole lifts     |                          |
|                            | <input type="checkbox"/> Inner Soles <input type="checkbox"/> Arch Supports |                          |

## Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

## About the Spouse or Parent

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Type of Work \_\_\_\_\_

## Experience with Wellness

Who may we thank for referring you to this office? \_\_\_\_\_

What type of wellness providers have you been to before? (Make a check mark ✓ if in past, circle ○ if current)

Chiropractor  Massage Therapist  Nutritionist  Acupuncturist  Personal Trainer/Fitness Expert

MAT Specialist  Life Coach  Other \_\_\_\_\_

What type of fitness have you participated in before? (Make a check mark if in past, circle if current & regular)

Yoga  Pilates  Tai Chi  Weight Lifting  Martial Arts  Running/Jogging  Meditation  Aerobics

Cycling/Spinning classes  Dance  Plyometrics  Other \_\_\_\_\_

Do you currently belong to a health club?  Yes  No

If no, would you be interested in learning how you can join one at a reduced rate?  Yes  No

Do you currently consume at least 8-10 servings of fruits and vegetables daily?  Yes  No

## Awareness of Your Body

Were you aware that...

The central nervous system (CNS) controls all bodily functions and systems?  Yes  No

Your CNS must be free of interference for optimal health and wellness to exist?  Yes  No

Have you had your nerve system checked for interference in the past 6 months?  Yes  No

If yes, when and by whom? \_\_\_\_\_

## Goals For My Care

People see wellness providers for a variety of reasons. Some go in the absence of symptoms and to promote wellness throughout a lifetime. Others go for the **relief** of pain/symptoms. Then there are some who go to **correct** the **cause** of their pain/symptoms/challenges. Your provider will weigh **your needs and desires** when recommending care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Symptomatic relief of pain or discomfort only
- Corrective Care:** Correcting the cause of the problem as well as relieving the symptoms.
- Comprehensive Care:** Bring whatever may be malfunctioning in the body to the highest state of health possible with wellness care (This includes Relief & Corrective Care if necessary).
- I want my wellness provider to select the type of care appropriate for me.

\_\_\_\_\_

Practice Member's Signature

\_\_\_\_\_

Date

## PAST / CURRENT HEALTH CHALLENGES

Please check each of the diseases or conditions that you have **currently** or had in the **past**. While they may seem unrelated to the purpose of the appointment, they can affect on your care. **If current, please place a "C" next to the item.**

- Headaches
- Sinus Problems
- Dizziness
- Cancer
- Loss of Sleep
- Hepatitis
- Discomfort Between the Shoulders
- Frequent Neck Pain
- Drug/Alcohol Dependency
- Arms/Legs/Hands Pain or Numbness
- Lower Back Problems
- Digestive Problems
- Ulcers/Colitis
- Heart Attack/Stroke
- Thyroid Problems
- Kidney Problems
- Other \_\_\_\_\_

- Congenital Heart Defect
- Heart Surgery/Pacemaker
- High/low Blood Pressure
- Psychiatric Problems
- Difficulty Breathing
- Rheumatic Fever
- Asthma
- Arthritis
- Tobacco Usage
- Venereal Disease
- HIV/AIDS
- Diabetes
- Tuberculosis
- Shingles
- Chemotherapy
- Anemia
- Other \_\_\_\_\_

### FOR WOMEN ONLY:

- Are you pregnant? Any Possibility?  
 Yes  No  Yes  No
- Date of last period? Are you nursing?  
\_\_\_\_\_  Yes  No
- Are you taking birth control pills?  
 Yes  No
- Do you experience painful periods?  
 Yes  No
- Do you have irregular cycles?  
 Yes  No
- Do you have breast implants?  
 Yes  No

## AUTHORIZATION FOR CARE

I hereby authorize the providers at DREAM Wellness to work with me through the use of procedures and techniques he/she is certified and/or licensed and qualified for, as he/she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. DREAM Wellness will not be held responsible for any pre-existing medically diagnosed conditions or for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

\_\_\_\_\_

Practice Member Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Guardian or Spouse's Signature

\_\_\_\_\_

Date

## Initial Consultation Form

As a wellness center, we typically do not focus on an individual's problems, complaints and symptoms; rather we specialize in teaching our member's how to live a proactive wellness lifestyle and provide the tools to do so. However, sometimes it is necessary to learn what may be required to assist in the healing process first, and the information is also important if the member intends on having some of the services reimbursed by an insurance company. Please fill out the form as honestly and accurately as possible. Remember, you don't need to have a "problem" to benefit from our services. ***If you are here with no known health challenges at all, you do not need to complete this form.***

Name: \_\_\_\_\_ Date \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Onset: \_\_\_\_\_

Caused by:  Work  Auto  Sports  
 Fall  Home Injury  Chronic  Other

*Please circle the appropriate response:*

**Overall Frequency of Challenge if any (Please circle one)**

**Constant** – 100% of the time    **Frequent** – 75%    **Intermittent** – 50%    **Occasional** – 25%

Has it:  gotten worse     stayed the same     comes and goes     getting better with time and/or other care

Has this challenge occurred before? Y / N    Have you seen other providers for this challenge? Y / N

**Overall Intensity of Challenge if any (Please circle one)**

**Minimal** (An annoyance but has no effect on activity)

**Moderate** (Tolerable with marked impairment of activity)

**Slight** (Tolerable with some impairment to activity)

**Severe** (Intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

\_\_\_\_\_

Does it interfere with your normal daily activities (work, family, recreation, sports)?

\_\_\_\_\_

Does your symptom(s) increase while performing your normal work duties? (Circle one)    Y    N

If yes, please circle the amount below that you feel your symptoms increase at work:

0%    10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

What aggravates the problem?

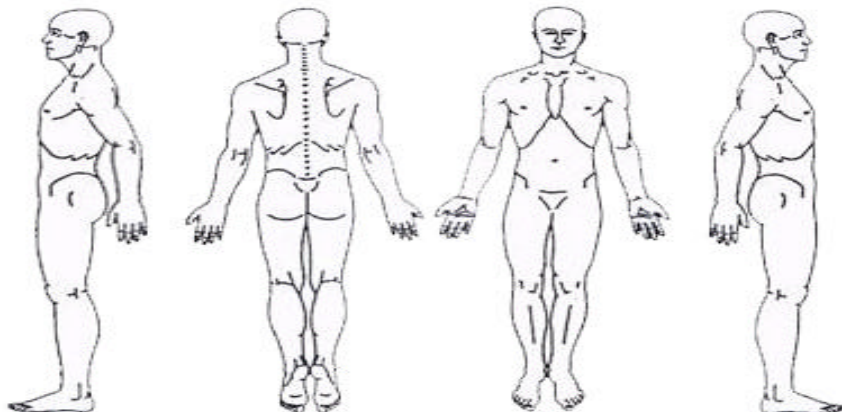
\_\_\_\_\_

What relieves the problem?

\_\_\_\_\_

If this problem went without being taken care of, how do you think it would affect you? \_\_\_\_\_

**Please indicate on the figures below where you generally have pain or discomfort even if it does not hurt today. Additionally, please draw any areas of broken bones, surgeries or other significant injuries to the body and write the approximate year next to it.**





**Notice of Privacy for:  
Patient's Protected Health Information**

**This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that appropriate services have been rendered.
- To determine patient's / practice member's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient / practice member.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign in logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

**You have the right to:**

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer, who is *Brian A. Stenzler, DC.*, and can be reached at 858-274-2225 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients / practice members may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have read and reviewed this notice with full understanding.

\_\_\_\_\_  
Practice Member Name (Print)

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date



## **TERMS OF ACCEPTANCE**

When a practice member receives services at D.R.E.A.M. Wellness®, it is essential for all parties to be working toward the same objective.

**Chiropractic** has only one goal. It is important that each practice member understand both the objective and the method that will be used 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.

**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 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 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.

**Massage** is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch to promote overall body wellness. The general benefits of massage, possible massage contraindications and the care procedures have been explained to me. I understand that massage is not a substitute for medical treatment, and it is recommended that I concurrently work with a Primary Caregiver for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal adjustments are not part of massage. I have informed the massage therapist of all my known physical conditions and medications currently taking and I will keep my massage therapist updated on any changes.

Any inappropriate comments, advances or gestures made towards the massage therapists or any provider will not be tolerated and will be asked to leave the premises immediately.

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

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

I therefore accept Chiropractic care and/or massage on this basis.

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

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



## 24 HOUR CANCELLATION POLICY

This form is to advise you of our office's 24 hour cancellation policy. Due to the overwhelming demand and limited appointment slots, we are unable to hold an appointment time for you if you are not able to keep it. Giving us notice of 24 hours or more allows us to fill the appointment time slot from the waiting list of others needing an appointment.

If you need to cancel your scheduled appointment, please notify us as soon as possible, at the very latest 24 hours prior to your scheduled appointment. If you cancel an appointment with less than 24 hours notice, you will be charged the full fee for the appointment you were scheduled for. (If you are scheduled for a service from a package previously purchased, you will lose that visit.)

By signing below, you acknowledge the above and fully understand the cancellation policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Credit Card # \_\_\_\_\_ Exp date \_\_\_\_\_ CID \_\_\_\_\_  
Only last 4 numbers if we have it on file

Zip Code \_\_\_\_\_