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? _____

Emergency Contact

Name _____
Relationship _____
Home Phone_____
Work Phone _____
Cell Phone _____

Reason For This Visit

Describe the purpose of this visit: _____
_____

Medications I Now Take

❒ Nerve Pills
❒ Pain Killers (including Aspirins)
❒ Muscle Relaxers
❒ Blood Pressure Medicine
❒ Insulin
❒ Stimulants
❒ Blood Thinners
❒ Tranquilizers
❒ _____
❒ _____

Health Habits

	No	Yes
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒
Do you drink coffee?	❒	❒

Do you exercise regularly? ❒ No ❒ Moderate ❒ Daily

Do you wear ❒ Heel Lifts ❒ Sole lifts ❒ Inner Soles ❒ Arch Supports

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? ❒Yes ❒No
Any Possibility? ❒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

D·R·E·A·M wellness

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?

_____

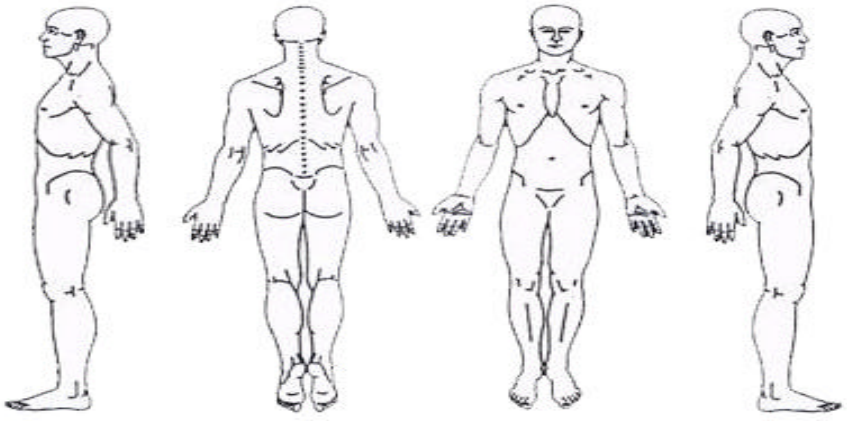
What relieves the problem?

_____

If this problem went without being taken care of, how do you think if 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.



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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

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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)

Chiropractic Informed Consent to Receive Care

I hereby request and consent to the performance of chiropractic procedures, including the potential use of diagnostic x-rays and any supportive therapies on me (or on the member named below, for whom I am legally responsible) by the doctor of chiropractic indicated named below, including those working at the clinic or office listed below or any other office or clinic below and /or other licensed doctors of chiropractic and support staff who now or in the future care for me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare services, in the practice of chiropractic there are some inherent risks to care, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, 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, and is in my best interests. Fractures are rare occurrences and generally result from some underlying weakness of the bone which our doctors check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke following a chiropractic adjustment are exceedingly rare and are estimated to be associated with the procedure between one in one million and one in five million cervical “manipulations”. The other complications are also generally described as rare.

I further understand that Chiropractic adjustments and supportive care is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms when present through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments(s) for care are final and no refunds will be issued. However, prorated fees for unused, prepaid services will be refunded if you wish to discontinue care.

I further understand that there may be options available to treat my condition and/or symptoms (if present) other than chiropractic procedures. These treatment options may include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. 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 to cover the entire course of care for my present condition and for any future condition(s) for which I seek care.

Name of Member: _____ Signature:_____

Name Printed of Guardian/parental and Relationship to Member: _____

Guardian/Parental Signature: _____ Date: _____

Doctor of Chiropractic Name: _____Signature of DC: _____ Date: _____

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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 _____

D·R·E·A·M wellness

Fee Schedule and Financial Policy for Chiropractic & Massage

Our experience has shown that it is wise to have an understanding with our practice members as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well being and we will do our best to help you.

Important: All practice members are responsible for full payment for the first visit (unless other arrangements have been made in advance.)

Who should receive bills for payment due on your account?
☐Self ☐Spouse ☐Parent ☐Worker's Comp.
☐Personal Health Insurance ☐Auto Insurance ☐Other _____

Insurance: We will verify all insurances and your benefits per your agreement with your carrier. Regardless of your coverage, the Doctor will give his/her recommendations and an appropriate care plan for each individual to obtain optimal results. Payment for services rendered is ultimately YOUR responsibility. (See Insurance Policies form for details) *Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.*

Many of our practice members receive our services as part of a package, hence the reason for the variation in prices. Also, fees may vary based on whether they are being paid on a cash or insurance basis. (All practice members, whether they have insurance or not, have the opportunity to receive our cash prices and may choose not to utilize their insurance coverage.) As part of our routine care, multiple services may be performed at a single time. (When using insurance, it is common to see some of these services listed on your explanation of benefits you will receive from your carrier. If you are unclear about what service you will be personally responsible to pay, please ask the office coordinator or provider prior to receiving the service.)

Service	Fee
Consultation	**No Charge**
Initial Chiropractic Exam	**$50-$250**
Chiropractic re-examination	**$60-$90**
***X-Rays (May be included in exam fee- inquire within)**	**$50 - $175**
Chiropractic Adjustments	**$25 - $65**
Neuromuscular Re-education, Extremity adjustment, Manual Therapy	**$45**
30 Minute Massage	**$40 - $80**
60 Minute Massage	**$49 - $110**

If you would like a full description of each service listed above, please ask your provider

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided DREAM Wellness with all necessary insurance documents and information by the time of the second visit.

I have read and agree to the above statements.

_____ _____ Date: _____
(Practice Member's Name) (Practice Member's Signature)

***It is understood and agreed that the payments to DREAM Wellness for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time. If you desire a copy of your films, they will provided to you at the cost incurred to DREAM Wellness.