Name: _____ ~~Patient #:~~ _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work Phone ( ) _____

Email Address _____ Male_____ Female _____

Social Security # _____ ~~Driver's Lic.#~~ _____ Birthdate_____

Occupation/Employer's Name and address _____

Single____ Married____ Divorced____ Widowed____ Spouse's Occupation/Employer _____

No. of children:____ ~~(In Canada)~~ Health Card#_____ Version Code: _____

Reason for consulting our office?_____

Who may we Thank for referring you to our office?_____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

Adult - (18 to present)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do /did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

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To reorder, call 800-285-2001

Whole Life Center for Health, Ltd.

Maria Aumick, D.C. ***Brian Carman, D.C.*** ***Bethann Sledziewski, D.C.***

600 North Hunter Highway, Drums Pa 18222 ***Phone: (570) 788-4484 Fax: (570) 788-4413***

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 towards the same objective.

Chiropractic has one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. The chiropractic objective is to allow correction of nerve interference to the central nerve system so that the body's innate ability to heal and express best life expression could be allowed. Following are some chiropractic terms that you will learn with your chiropractic care at our office.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment 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 throughout a lifetime.

Meninges: Three structural membranes that cover and protect the brain and spinal cord. They also sheath and protect each cranial and spinal nerve root and suspend inside the brain for internal protection.

Adjustment: An adjustment is the specific application of gentle forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine and balance of the meninges.

We do not offer to diagnose or treat any disease or condition other than correction of the vertebral subluxations and balance of the meninges. 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 recommend that you seek the services of a health care provider who specializes in that area. Regardless of what your disease or condition is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR CHIROPRACTIC OBJECTIVE** is to allow correction of nerve interference to the expression of the body's innate healing. Our only method is specific adjusting to correct vertebral subluxations and balance of the meninges.

In signing, I am accepting chiropractic care, from any attending chiropractor at Whole Life Center for Health, Ltd., for myself or the specified patient/minor named below.

_____ _____

Patient Name (Please Print) **Signature of patient, parent or guardian**

Date: _____

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INFORMED CONSENT

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

I authorize any and all professional associates of Whole Life Center for Health, Ltd. to review my records as needed for my health care.

I authorize the use of this form as a release of records to my insurance company(ies) and/or legal representation. This authorization includes the disclosure of my medical history, findings, consultations, chiropractic care, x-rays, reports, chiropractic analysis and chiropractic prognosis.

I understand that I am responsible for my bill upon the date of service unless previous arrangements have been agreed upon.

I understand and agree that any insurance payments made directly to Whole Life Center for Health or any of its associates due to accidental injury or other related circumstances will be placed directly into my account for services rendered.

I understand, and give consent to, the following appointment reminders that may be used: a postcard being mailed to me at the address I have provided and/or a telephone or text message being left either directly with me, on my answering machine or voicemail, of with the individual answering the telephone.

I understand that other practice members may view my signature on a sign-in sheet.

I understand that if I revoke this consent at any time, I can be refused care at Whole Life Center for Health, Ltd.

I permit a copy of this authorization may be accepted with the same force and authority as the original.

Finally, **initial** chiropractic appointments have ***a fee appropriate to the time lost if not given proper notice (3 business days.*** We require a minimum of 24 hours advance notice to cancel all other appointments including chiropractic visits. By not canceling in advance, you are preventing others from using that time for their own health. A ***$30 cancellation fee*** will be charged for these visits. Insurance companies will not reimburse for missed visits, therefore, this will be your sole responsibility.

_____ _____

Name of Individual (Printed) Date

_____ _____

Signature of Individual or Legal Guardian Relationship

_____ _____

Signature of Witness Date Witnessed

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FEE AGREEMENT

Name(s) _____

Address _____

_____

Date of Birth _____ Phone _____

This fee agreement will confirm the contract between the patient, as noted above, and Whole Life Center for Health, Ltd., in terms of fees that will be charged to the patient for chiropractic services, and for which the patient is legally responsible.

We agree that bills for services will be properly submitted to the patient's insurance provider and we will honor co-pay policies as set forth by the insurance carrier.

All services billed to an insurance carrier will be itemized on an invoice prepared on behalf of the patient upon the patient's request. Different services, diagnostic tests, and procedures have individual identifying codes, as well as fees attached thereto, and the patient has the right to be advised of the fees for services provided on his/her behalf.

Because the patient may be unable to afford the customary fees charged, and in an effort to provide chiropractic care even in light of that circumstance, the parties agree that, with the showing of hardship, Whole Life Center for Health may, at its discretion, reduce or forego any customary fee for services.

It is specifically agreed between the parties that any such determination on the part of Whole Life Center for Health, Ltd. is confidential and that it is not the standard for the assessment and collection of fees for services. The decision of Whole Life Center for Health, Ltd. to reduce or forego for services is in no way applicable to or binding upon the assessment and/or collection of fees for future services.

The parties agree and acknowledge that the terms and conditions of this agreement, and not any term or condition of financial forbearance by Whole Life Center for Health, Ltd., is confidential in nature. Neither party will discuss and/or reveal the terms hereof without the express written consent of either party.

It is further agreed between the parties that, in the event that chiropractic services and/or procedures are provided in treatment for an automotive related injury or other physical injury for which recovery has been sought from a third party, the patient acknowledges that he/she continues to be liable for payment of his/her bills for those services. Additionally, in such a case, the parties acknowledge that unpaid bills for services and/or procedures provided by Whole Life Center for Health, Ltd will be a lien against any settlement or financial recovery for such injury. The Whole Life Center for Health, Ltd. specifically reserves the right and discretion to provide services on that basis, and to assert a lien against any settlement or financial recovery for such injury.

Special Terms: ***Per our telephone conversation on _____, should your insurance not cover chiropractic care at our office, the initial consultation fee is $_____, visits 2-4 are $_____ each, and all additional appointments are $_____ each, unless alternative financial arrangements have been made.***

_____ _____

Maria Aumick, D.C. Date

Brian Carman, D.C.

Bethann Sledziewski, D.C.

_____ _____

Patient Date

Dear Whole Life Center for Health Friends,

As many of you know, we keep an extremely full schedule here at WLCFH, and in order to ensure that our community gets what they need, we have recently found it necessary to enforce our cancellation policy. Please read the policy below and sign at the bottom. Please feel free to address any questions to our office.

Cancellation Policy

You should receive a reminder call 1 to 2 days before your appointment, however the reminder call is a courtesy and very occasionally we are unable to make them due to busy scheduling. Unfortunately, if we were unable to give you a courtesy call, WLCFH is not responsible for your missed appointment.

We require a minimum of 24 hours advanced notice to cancel an appointment. All appointments missed or canceled without 24 hour notice will be charged a fee of $30 per person. Insurance companies will not reimburse for missed visits, therefore, this will be your responsibility.

Existing client appointments that are not cancelled on time or general no shows will result in the fee which will be applied to the client's account and a statement will be mailed.

This policy ensures quality service and patient convenience at the center. By complying with this policy, you help our patient community enjoy professional, efficient, effective service.

By signing below, I acknowledge receipt of this Cancellation Policy. By signing this form, I acknowledge my agreement with all aspects of this policy and I authorize The Whole Life Center for Health to bill me personally (not my insurance carrier) if I do not give the required cancellation notice as outlined in this Cancellation Policy. We do understand that emergency circumstances occasionally arise, and those will be given appropriate consideration.

Thank you for your time and understanding as we work to make Whole Life Center for Health a better place for all of us.

Signature: _____ Date: _____

Patient Name (printed):

_____