Natural Healing & Wellness Center

427 W. 100 S. Ste. A., St. George, UT (435) 674-5454

Name:____ **Date:**__________________

List below, in order of top priority, what results you would like to achieve in the next <u>three months</u> with our help and why: (ie. Be able to enjoy my hobby without discomfort. Have more energy to dedicate to my spouse and children. Be able to function without the constant need of medications. To stay healthy so I can maintain. an active lifestyle)

Goal 1. ________________________________Why you desire this: ____________________________

Goal 2. ________________________________Why you desire this: ____________________________

Is there anything that you feel would hinder you from achieving your goals? __________________________

What is your level of commitment to taking care of these concerns? Low —- Medium —- High

A. **Check off any of the following symptoms you have experienced in the past 6 <u>months</u> and indicate on the line to the right of the condition a rate of 1-10 (10 being the most extreme):**

B. Existing Patients: Indicate % of improvement on the right of the line of the conditions checked below.

- ☐ Acid Reflux _____
- ☐ Allergies _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Autism _____
- ☐ Auto Immune _____
- ☐ Back Pain _____
- ☐ Balance (difficulty) _____
- ☐ Central Nervous System Disorder____
- ☐ Chest Pain _____
- ☐ Clicking or Popping Jaw _____
- ☐ Cold Feet _____
- ☐ Cold Hands _____
- ☐ Cold Sweats _____
- ☐ Colic _____
- ☐ Colitis _____
- ☐ Constipation or Diarrhea _____
- ☐ Decrease in Range of Motion _____
- ☐ Depression _____
- ☐ Digestive Disturbance _____
- ☐ Dizziness _____
- ☐ Elbow Pain _____
- ☐ Eyes Sensitive to Light _____
- ☐ Facial Pain _____
- ☐ Fatigue/Tired _____
- ☐ Fibromyalgia _____
- ☐ Focus (lack of) _____
- ☐ Frequent/Painful Urination _____
- ☐ Hay Fever _____
- ☐ Headaches/Tension _____
- ☐ Hip Pain _____
- ☐ Hormonal Imbalance _____
- ☐ Immune Suppression _____
- ☐ Irritability _____
- ☐ Jaw Pain/Teeth Clenching _____
- ☐ Knee Pain _____
- ☐ Lacking Direction _____
- ☐ Low Libido _____
- ☐ Loss of Balance _____
- ☐ Loss of Smell _____
- ☐ Loss of Taste _____
- ☐ Low Energy _____
- ☐ Memory Loss _____
- ☐ Mental Clarity _____
- ☐ Neck Pain _____
- ☐ Nervousness or Anxiety _____
- ☐ Numbing/Tingling in Feet _____
- ☐ Numbing/Tingling in Hands _____
- ☐ Pain Anywhere in Body _____
- ☐ Peacefulness (lack of) _____
- ☐ Ringing/Buzzing in Ears _____
- ☐ Shortness of Breath _____
- ☐ Shoulder Pain _____
- ☐ Sleeping Problems _____
- ☐ Stamina _____
- ☐ Tension Across Top of Shoulders____
- ☐ Tension Between Shoulder Blades _____
- ☐ Walking (difficulty)
- ☐ Wrist / Hand Pain

C. Which of the above bother you the most or is your main concern? ____________________________________

How *long* have you been bothered by this concern? ____

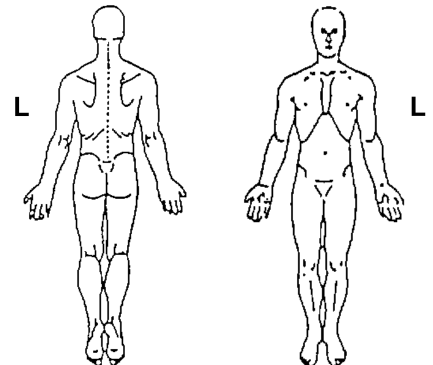
Describe ***how it feels or affects you*** when it is at its' worst? ____________________________________

How does this condition ***inhibit your life***? ____

D. Do you suffer from any other condition that is not listed above? _____________________________________

E. Please circle, on the body to the right, the areas of discomfort or concern: ——›

F. Mark each circled area with a number between (1-10) "1", being mild, and "10", extreme



<u>LIST ANY PAST ACCIDENTS, FALLS, OR SURGERIES</u>

(Car & Motorcycle accidents, work injuries, school or sports injuries, etc.) ______________________

____

Previous fractures ____

Were you ever knocked unconscious? YES / NO] If yes, when/why? __________________

____

Back Operations / Date ____________ Female Organs / Date____________

Other Surgeries/Dates____

____

Patient Signature or Guardian Signature

Name: ____ Age: _____ Date of Birth: _________________

I would like to be addressed as: ______________________________ ☐ Single ☐ Married ☐ Widowed ☐ Div/Sep

E-Mail ____________________________ (This will allow you to receive specials and information exclusive to our office)

Address: ____
City: ___________________________ State: _____ Zip: _________ Social Security #: ____________________

Home Phone: ______________________Cell Phone: ____________________Work Phone: _______________
Employed By: ______________________________ Occupation: ______________________________________

Name of Spouse: ____ Date of Birth:__________________
Spouse Employed By: _________________________Occupation: ___________________________________

Whom may we thank for referring you to our office?_________________________Relationship to you:______________

Have you seen a **holistic physician** prior to this visit? Y N Whom? ____

Have you seen a **chiropractor prior** to this visit? Y N Whom? ____

Please circle any of the following that pertain to you:

1.	Are you pregnant or have any possibility of being pregnant?	Yes	No
2.	Do you have a pacemaker?	Yes	No
3.	Have you ever had an organ transplant?	Yes	No
4.	Do you suffer from psychotic episodes or epileptic seizures?	Yes	No

If you answered yes to any of these questions, some of the therapies and treatments used in our office may not be suitable for you to use.

PLEASE READ CAREFULLY

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 reduction 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.

It is the policy of this office that payment for any services rendered be made at the time of the office visit. All services received are the patient's responsibility and if not paid within a reasonable time period, will be turned over to a collection agency and subjected to finance charge. I/we agree that all supplements/products that are paid for are non-refundable at the time of payment. I/we agree to pay all attorney's fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue this matter which may be as much as 50% of the principal balance owing. I/we agree to pay interest at the rate of 1.5% per month (18% per year) or a minimum of a $5.00 monthly billing fee, whichever is greater, until the balance is paid in full.

It is the responsibility of the patient to keep records of all payments to Natural Healing and Wellness Center. All receipts must be processed and received by patient at the time of transaction. No receipts may be post dated.

____
Patient Name (please print)

______________________________________ ____________________
Patient Signature or Guardian Signature Authorizing Care Date

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Below are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality control or other operation purposes.
- We may use your health information within our practice and community in order to educate others as to the benefits of the integrated health care which you receive at our office.
- We may use your name, address, phone number, email address, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive a call from our office, a message will be left on your answering machine.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing, We are not required to agree to your restrictions, however, if we agree, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Authorization for Release of Patient Information

I hereby give consent that Medical records, Financial statements, Appointment information, and X-rays may be released to those below upon request in order to assist me in my endeavors:

(Please list the names of those whom you authorize to have the above information.)

____

____

This release shall remain in force until written notification of any changes are made by filling out a new Authorization for Release of Patient Information.

I hereby state that the information of the patient forms is true and correct. I declare myself to be physically sound and suffering of no condition which would prevent my participation in receiving therapiesand treatments involving electrical frequencies and/or stimulation. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of chiropractic health care. It is understood and agreed the amount paid the doctor for any x-rays is for examination only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed condition, nor for any medical diagnosis.

I understand the nutritional supplements and homeopathic remedies, treatments and modalities used and recommended by *NATURAL HEALING & WELLNESS CENTER* are largely experimental, and are not intended to treat, diagnose, prevent or cure any disease and that the effect of these supplements and homeopathic remedies may cause sensitivity, allergic or detoxification symptoms. I further understand that I am solely responsible for the choice and appropriateness of the supplements, remedies, treatments and modalities that I choose to use.

By signing this agreement, I hereby release and discharge *NATURAL HEALING & WELLNESS CENTER*, their officers, employees, representatives, service providers and all other *NATURAL HEALING & WELLNESS CENTER* affiliates from any liabilities.

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Patient Name

____ _______________

Patient Signature or Guardian Signature DATE