ROMAN FAMILY CHIROPRACTIC PLLC

Healthy by Choice not by Chance

Name:_____ **Date**:_____

Address:_____**City**:_____**State**:____**Zip**:_____

Phone #:_____**Cell Provider**:_____**Text Reminders** (circle) Yes / No

Birth Date:_____ **Age**:_____ **Sex** (circle) M / F - single – married - widowed – divorced

If Female, any chance of being pregnant? (circle) Yes / No (If yes, how far along)_____

Email Address:_____

Occupation:_____**Employer:**_____

Do you enjoy your work? (circle) Yes / No

Spouse's Name:_____ **Spouse's Occupation**:_____

Name and Ages of Children:_____

Emergency Contact:_____ **Phone#:**_____

Whom may we thank for referring you or how did you hear about us? (Circle all that apply)

Person's Name_____		Google
Printed Advertisement_____	Radio	Website
Other_____	Facebook	Instagram

Have you been adjusted by a chiropractor before? (circle) Yes / No

Who:_____ **Date of last Adjustment:**_____

Frequency of visits: _____times a week/month - **Duration of care:** _____weeks/months/yrs

Have you ever had X-Rays of your spine? (circle) Yes / No (If yes, when)_____

Anything about your Nerve System and Spine we should know about?_____

_____

What is your daily fluid intake in cups: *Coffee*____/day *Alcohol*____/day *Water*____/day *Soda*____/day

Sleep & Rest Habits

Daytime naps: Yes / No - **Hours a night:**_____/hrs - **Do you wake up refreshed?** Yes / No

Exercise & Relaxation Habits: (What do you do and how often) _____

_____

Do you use any prescription medications, over the counter and/or recreational drugs? Yes / No

(If yes, please list) _____

_____

Initial Health History

- **Past Health History** (General health, illnesses, injuries, hospitalizations, surgeries)

_____

_____

_____

Check any of the symptoms or conditions that apply to you?

☐ Neck Pain	☐ Sciatic Pain	☐ High Blood Pressure
☐ Mid-Back Pain	☐ Leg or Hip Pain	☐ Problem Sleeping
☐ Lower Back Pain	☐ Shoulder/Arm Pain	☐ Low Energy/ Fatigued
☐ Ringing in ears	☐ Carpal Tunnel	☐ Weight Trouble
☐ Vertigo/ Dizziness	☐ Numbness	☐ Digestive Issues
☐ Shortness of Breath	☐ Tension in Shoulder	☐ Menstrual Pain
☐ Asthma	☐ Anxiety	☐ Cancer
☐ Allergies	☐ Depression	☐ Other_____

- **Which above symptom is worst?**_____
  How long have you had the symptom?_____
  When is it at its worst, how does it feel?_____

- **The following three areas below can contribute to nerve interference and diminish quality of life. Please *circle* the areas that apply to you and when.**

C = Child T = Teenager A = Adult N = None

Physical Stress				
Birth Stress	C	T	A	N
Slip/ fall	C	T	A	N
Car Accident	C	T	A	N
Sports Injury	C	T	A	N
Physical Abuse	C	T	A	N
Work Injury	C	T	A	N
Poor Posture	C	T	A	N
Sitting on wallet	C	T	A	N
Stomach sleeper	C	T	A	N
Computer work	C	T	A	N
Repetitive lift/bending	C	T	A	N
Prolonged Driving	C	T	A	N
Prolonged Standing	C	T	A	N
Prolonged Sitting	C	T	A	N
Surgery/Broken bones	C	T	A	N
Lack of Physical Activity	C	T	A	N
Excess Physical Activity	C	T	A	N

Emotional Stress				
Family	C	T	A	N
Relationships	C	T	A	N
Career	C	T	A	N
Money	C	T	A	N
Fast paced life	C	T	A	N
Hold in Feelings	C	T	A	N
Quick Tempered	C	T	A	N
Perfectionist	C	T	A	N
Procrastinator	C	T	A	N
Loss of loved one	C	T	A	N

Chemical Stress				
Environmental	C	T	A	N
Smoker	C	T	A	N
Secondhand Smoke	C	T	A	N
Caffeine	C	T	A	N
Artificial Sweeteners	C	T	A	N
Prescription Drugs	C	T	A	N
Recreational Drugs	C	T	A	N
Poor Diet	C	T	A	N
Vaccinated	C	T	A	N

Rate your combined overall level of stress from all sources listed above: (circle)
No Stress – 1 – 2– 3– 4– 5– 6– 7– 8– 9– 10– High Stress

What do you feel is the primary stress in life?

Informed Consent to Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, 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. One of the rarest complications associated with chiropractic care, occurring at a rate of one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person 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 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 wisdom/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 a chiropractic spinal evaluation, 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 disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

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. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

Prior to receiving chiropractic care at *Roman Family Chiropractic PLLC*, a health history and physical examination will be completed. These procedures are performed by highly qualified and trained staff members and are performed to assess your specific condition, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if further examination 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 your care plan prior to beginning care.

Thank you for choosing Roman Family Chiropractic. Our office would like to inform you of the services you will receive today either complimentary or at a reduced rate. The standard fee for the initial consultation, evaluation and report of findings is $75.00. This will include the following.

- Consultation
- Evaluation including SEMG, bilateral scales, muscle testing, range of motion and palpation of the spine.
- Report of findings

This fee, whether complimentary or reduced ***does not*** cover any of the following.

- X-rays
- Massage (unless a drawing winner including a 20minute chair massage)
- Adjustment
- Supplements

Because we are performing your initial office visit and report of findings on a complimentary or reduced basis, we do require 24 hour's notice for any cancellation or rescheduling for any future appointment. If ample notice is not received, we do enforce a $25 missed appointment fee. Thank you for your consideration.

I understand and accept that there are risks associated with chiropractic care and give my informed consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. By signing below, you accept and acknowledge what services are being offered to you.

I, (Printed name)_____ (Signature)_____undertake chiropractic services on the understanding of an agreement with, the above explanation. _____(Date)

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____ (Print name) give permission for my child to receive chiropractic care.