Indigo Dragon
Ancient Wisdom • Modern Touch

PERSONAL HISTORY

Last Name: First Name:

Home Address:

City: State: Zip:

Home Phone: Cell Phone:

Work Phone: E-mail:

Occupation: Employer:

SSN: Driver's License #:

Date of Birth: / / Age: Sex: M F Marital Status: S M W D

Emergency Contact: Relationship: Phone:

Who may we thank for referring you?

METHOD OF PAYMENT

□ Cash □ Check □ Credit Card

Who is responsible for your bill, You and:

□ Workers' Comp □ Auto Insurance □ Medicare □ Other_____

INSURANCE INFORMATION

Health Insurance Name:

Policy #: Group #:

Insured Person's Name: Date of Birth: / /

WORKERS' COMPENSATION & PERSONAL INJURY

□ Workers' Comp □ Auto accident Date of Injury:

Claim #: Adjustor: Adjustor Phone:

Attorney: Attorney Phone:

I have read all information on this form and have completed this form to the best of my knowledge and I certify this information is true. I hereby instruct and direct my insurance company (if applicable) to pay by check made out to Paradigm Wellness, the professional expense benefits allowable under my current insurance policy for services rendered to me or my dependent. I will notify you of any changes in the above information. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

Patient Signature: **Date:**

OFFICE USE ONLY

DATE: ID #:

ICD-9 CODE:

CURRENT HEALTH CONDITION

Unwanted Health Condition:

Other doctors seen for this condition: □ Yes □ No — Who?

Type of Treatment: — Results:

When did it begin? — Has it occurred before?

It is getting … □ Better □ Worse □ Same

Rate the severity on a scale from 1 (least) to 10 (severe)

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

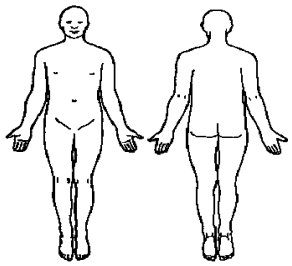
How often do you have this condition?

Is it constant or does it come and go?

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Drugs you now take:



Mark an X on the picture where you continue to have pain, numbness or tingling

PAST HEALTH HISTORY

Have you ever received □ Chiropractic care □ Acupuncture For?

Date of Last:

□ Physical Exam
□ Spinal Exam
□ MRI, CT-Scan, Bone Scan
□ Spinal X-Ray
□ Chest X-Ray
□ Blood Test
□ Urine Test

Check any of the following conditions you have had:

□ AIDS/HIV
□ Alcoholism
□ Allergy Shots
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding disorders
□ Breast lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical dependency
□ Chest Pain
□ Chicken pox
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fatigue
□ Fractures
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart disease
□ Hepatitis
□ Hernia
□ Herniated disk
□ Herpes
□ High cholesterol
□ Infertility
□ Kidney disease
□ Liver disease
□ Measles
□ Menstrual irregularity
□ Migraine headaches
□ Miscarriage
□ Mononucleosis
□ Multiple sclerosis
□ Mumps
□ Osteoporosis
□ Pacemaker
□ Parkinson's disease
□ Pinched nerve
□ Pneumonia
□ Polio
□ Prostate problem
□ Prosthesis
□ Psychiatric care
□ Rheumatoid arthritis
□ Rheumatic fever
□ Scarlet fever
□ Stroke
□ Suicide attempt
□ Thyroid problems
□ Tonsillitis
□ Tuberculosis
□ Tumors, growths
□ Typhoid fever
□ Ulcers
□ Vaginal infections
□ Venereal disease
□ Whopping cough
□ Other

Are you pregnant? □ Yes □ No Due date:

Have you ever had?	**DESCRIPTION**	**DATE**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

WELLNESS QUESTIONS

Exercise Habits?

Type:_____ _____ days/ _____ week

Nutrition Habits?

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

Fluids_____

Are you taking any supplements? □ EPA/DHA □ Digestive Enzymes □ Vitamin D3 □ Probiotics □ Multivitamin
□ Other _____

Where did you purchase them? □ Costco □ Health Food Store □ Supplement Store □ Health Professional

Stress Levels: □ Low □ Moderate □ High Explain _____

My ability to handle daily stresses: □ Great □ Moderate □ Challenging

TYPES OF CARE

Most patients that come to our office have one of three objectives in mind concerning their health care. Some patients come for symptomatic relief (Relief Care). Some are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Others want to take their health to the highest level (Wellness Care). Your Doctor will weigh your needs and desires when recommending your care program.

RELIEF CARE

Relief Care addresses your symptoms only and once they have been eliminated and remain absent for 2 weeks, we will do a baseline exam and use it as a comparison the next time you return.

CORRECTIVE CARE

Corrective Care addresses your reason for consulting our office. This care ends when the indicators of nerve system disturbance and subluxation have resolved. This plan will include information and coaching on wellness recommendations.

WELLNESS CARE

Wellness Care addresses your daily lifestyle. How you eat, move and think actually causes your dysfunction in your nervous system and the rest of the body. This level of care promotes the highest levels of health and performance.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care** □ **Corrective Care** □ **Check here if you want the Doctor to select the type of care appropriate for your condition**

□ **Wellness Care**

I am interested in the following…

Get Fit……	**N/A**	**1**	**2**	**3**	**4**	**5**
Eat Better……	**N/A**	**1**	**2**	**3**	**4**	**5**
Reduce Stress……	**N/A**	**1**	**2**	**3**	**4**	**5**
Stop Smoking……	**N/A**	**1**	**2**	**3**	**4**	**5**
Reduce Pain……	**N/A**	**1**	**2**	**3**	**4**	**5**
Increase Mobility and Improve Posture……	**N/A**	**1**	**2**	**3**	**4**	**5**
Increase Energy……	**N/A**	**1**	**2**	**3**	**4**	**5**
Sleep Better……	**N/A**	**1**	**2**	**3**	**4**	**5**
Improve Digestion……	**N/A**	**1**	**2**	**3**	**4**	**5**
Learn About Wellness……	**N/A**	**1**	**2**	**3**	**4**	**5**
Other _____	**N/A**	**1**	**2**	**3**	**4**	**5**

INFORMED CONSENT

The determination of an appropriate plan of medical management or orthopedic conditions may involve or include the utilization of muscle testing and/or exercise rehabilitation procedures. Should these procedures be deemed appropriate in your case, you will be examined by a doctor to determine if you have any conditions that indicate you should not engage in muscle testing or rehabilitation exercises.

I understand that, as with any form of exercise, muscle testing and rehabilitation procedures carry with them a small inherent risk of injury, which includes but is not limited to minor strains of the specific muscles being used during testing or rehabilitation. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complication associated with physical examination, physiotherapeutic, massage therapy, acupuncture and spinal and extremity adjustive procedures. These complications include, but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, electrical shock, fractures, disc trauma, minor burns and stroke. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in a physical examination, physiotherapeutic, manipulative, massage, muscle testing/rehabilitation acupuncture and/or other procedures as deemed appropriate by my doctor. If at any time I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Should I decide to receive treatment, I understand that I will be ultimately responsible for any and all charges incurred at Paradigm Wellness. After a charge is 30 days past due a finance charge of 1.5% per month may be added. If any of my checks bounce, I will be billed a service fee. I hereby authorize Paradigm Wellness to disclose medical information pertaining to my case to medical/technical consultants deemed appropriate by my doctor and submit claims to my insurance carrier on my behalf. However, I understand that verification of my eligibility and benefits is not a guarantee of payment.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Patient/Guardian's Signature: **Date:**