

Welcome to Center for Healing Life

This document constitutes informed consent to treat for health care.

CA Code of Regulations, Title 16, Div. 4, Section 319.1

- On the days of your visits, the doctor will conduct various exams, which may include neurology (nerves), orthopedic (joints), Chiropractic (spinal), nutritional, neuro-emotional and kinesiological (muscle) exams. Based on the results of these exams, your health history and that of your family, clinical judgments will determine the types of treatment needs and if there should be a need for x-ray, lab analysis and/or referral to a specialist. In addition to specific spinal adjustments you may require nutritional counseling, exercise therapy and neuro-emotional support. Historically none of these constitute a risk of harm.
- When a person seeks health care at CFHL and we accept a client for health care, it is essential for both to be working towards the same goal: HEALTH BALANCE. We have only one goal. It is important for each patient to understand this goal and the methods that will be used to attain it. You need to comply and do your part in your return to health.
- Subluxations are mechanical interferences to the normal flow of mental impulses traveling over the nerve pathways. Our goal is to locate, analyze and correct these subluxations by specific adjustments of the body. These adjustments are intended to reduce nerve interferences thereby allowing the innate healing abilities of the body to work at maximum efficiency. With a proper nerve supply restored, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and recovery is complete; in others, only partially.

Should you experience discomfort inform us immediately or by phone or E-mail.

- We do not offer to diagnose or treat any disease or condition other than imbalances. However, if during the course of an examination, we encounter unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.
- Our office is on a private pay basis; payment is expected at the time services are rendered.

I, _____ have heard and read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care

in this office have been answered to my complete satisfaction. I therefore give consent and accept care on that basis

signature _____ date _____

For minor _____ I, _____, being the parent or legal guardian fully understand the above terms and grant permission for treatment. date _____

New Patient Intake Form

Welcome! Holistic health and preventive care are possible when the doctor has a complete understanding of your health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Personal Information

Name _____ Today's Date: ____/____/____

Female ___ Male ___ Age _____ Date of birth ____/____/____

Phone: Home (____) _____ Work (____) _____ Mobile (____) _____

Preferred ___ Home ___ Work ___ Mobile ___ Is it OK to leave messages? ___ Yes ___ No

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Email address _____

Are you interested in receiving email newsletter? ___ Yes ___ No

If the patient is under the age of 18:

Name of mother _____ Phone number _____

Name of father _____ Phone number _____

Who may we thank for your referral? _____

When did you last receive health care? _____

Who? _____ Chiropractic? _____

What is your most important reason for making this appointment? _____

Please list other health concerns, in order of importance: _____

Emergency Contact

Name _____

Relationship _____

Phone Number _____ Day (____) _____ Evening (____) _____

Address _____ Apt# _____

City _____ St _____ Zip Code _____

Health History

Please list any known allergies (environmental, drug, food): _____

Do you take any of the following over-the-counter medications? Please check any that apply:

- Aspirin
- Ibuprofen or acetaminophen
- Antihistamine
- Sleeping pills
- Laxatives
- Appetite depressants
- Antacid
- Medicine to stay awake

Please list **medicines and supplements** that you are taking or have taken in the last year:

Medication	Dosage	Dates	Reason for taking

If any of the following apply to you, please indicate dates:

Hospitalization _____	Surgery when _____ for _____	Endoscopy _____
		When _____ results _____
Surgery when _____ for _____		Colonoscopy _____
		When _____ results _____
X-ray _____ where _____ for _____		Mammogram _____
		When _____ results _____
MRI _____ where _____ for _____		CT scan _____ when _____ results _____
Rectal exam _____ when _____ results _____		Bone Scan _____ when _____ results _____
Electrocardiogram _____ when _____ results _____		Other _____

For the following conditions and symptoms, please indicate any that apply to you by marking

I/self, M/mother, F/father, S/sibling, C/child, O/other blood family

- | | | |
|--|--|--|
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Weakness | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Varicose veins or hemorrhoids | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Numbness / tingling / paralysis | <input type="checkbox"/> Gastrointestinal disorder |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Gastritis or ulcers |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Excessive thirst / hunger |
| <input type="checkbox"/> Feel unsafe at home | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Head injury | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Frequent antibiotic use | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Frequent colds or flu | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Impaired hearing / vision | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Problems with urination |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma, hay fever, rashes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Attempted suicide |
| <input type="checkbox"/> Alcoholism or substance abuse | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Other |

When and where are your symptoms worse? At home At work Upon waking
 Morning Afternoon Evening Overnight No pattern Other

Payment is due at the time of service. Cash or check is preferred. Credit Card fees will be charged to the client.

For Men Only

Please check all that apply to you:

- Prostate exam _____ / _____ / _____
- Regular self testicular exam
- Impaired fertility
- Sexual abuse
- Heel Pain

- Abnormal discharge from penis
- Pain or lump in scrotum
- Prostate problem
- Sexually transmitted infection

For Women Only

- Last menses _____ / _____ / _____
- Last pap smear _____ / _____ / _____
- Age menses began _____
- Number of pregnancies _____
- Number of live births _____

If you are still having periods:

- Average number of days of bleeding _____
- Average number of days in cycle _____
- Bleeding is Regular Irregular
- Light Medium Heavy
- Symptoms Bleeding b/n periods Mood swings
- PMS Painful menses Breast tenderness

If you are no longer having periods:

- Hot flashes Vaginal dryness
- Dry skin Changes in memory
- Spotting Changes in libido
- Facial hair Changes in mood
- Hair loss Hormone replacement therapy
- Incontinence Urinary tract infections

Please check all that apply to you:

- Hysterectomy _____ / _____ / _____
 - Abnormal pap smear
 - Breast pain / lump / nipple discharge
 - Sexual difficulties
 - Frequent vaginitis / chronic yeast infections
 - Abnormal vaginal discharge
 - Endometriosis
 - Polycystic ovary syndrome
 - Sexually transmitted infection
 - Pelvic inflammatory disease
 - Uterine fibroids
 - Impaired fertility
 - Sexual abuse
 - Regular self breast exam
 - Sexually active
 - Use methods to prevent pregnancy and/or sexually transmitted infections:
- Current _____
- Past _____

Lifestyle History

Please check any that apply to you and fill in corresponding details:

- Exercise _____ hours per week
 - Activities _____
 - Watch TV _____ hours per week
 - Tobacco use _____ packs per day
 - Alcohol use _____ drinks per week
 - Recreational drug use
 - Mercury amalgam fillings
 - Employed outside the home
 - Occupation _____
 - Hours per week _____
 - Employer _____
 - Do you enjoy your work? Yes No
 - Level of stress Low Average High
 - Toxic exposure _____
 - Major life change in last year _____
- Height _____
 - Weight _____
 - Weight one year ago _____
 - Maximum weight _____
 - When? _____
 - Sleep _____ hours per night
 - Is this enough? Yes No
 - Meals per day _____

The above information is true to the best of my knowledge.

Signature (Parent or guardian if patient is under 18 years old)

_____/_____/_____
Date