

# Body Awakening Chiropractic

Dr. Iwona Szpiech  
4405 Manchester Avenue; Suite 108  
Encinitas, CA 92024  
760.889.6096

Thank you for your interest in health, healing, and Body Awakening Chiropractic. Congratulations upon your first step in a profound, new healing model: Network Spinal Analysis.

At Body Awakening, you will explore the incredible healing power of your own body while learning to develop long-term strategies for taking care of your own health.

This package includes:

- ✓ *History* form
- ✓ A statement about *Terms of Acceptance in This Office*.
- ✓ A map to the office

To prepare for your initial office visit, please follow this checklist:

- Thoroughly complete and sign the history form before coming to the office.
- Read, sign, and date the *Terms of Acceptance in This Office*.
- Plan to spend up to an hour in the office for your initial visit.
- Please be on time for your appointment.

Your journey towards greater health and awareness begins with a very gentle entrainment of your nervous system. This consists of soft touches to your spine and adjacent soft tissues. Our objective is to enhance your neural and spinal integrity. No matter where you are in your experience; whether you wish to rid yourself of a pain, a symptom, or a disease, or you wish to grow beyond your present level of awareness, with a clear, flexible nervous system, you are on your way.

We look forward to meeting you for your initial evaluation.

Warmest regards,

Dr. Iwona Szpiech, D.C. and her Team

P.S. Please remember to bring your completed paperwork with you.

# TERMS OF ACCEPTANCE IN THIS OFFICE

## STATEMENT OF CLINICAL OBJECTIVES

This document defines what we do and what we do not do in this office so you may be sure of our responsibilities and your responsibilities in this relationship.

We recognize that there is an intelligence within each individual that not only keeps us alive, but coordinates, repairs, renews, and heals every cell of the body.

We recognize that the nervous system is the main distribution center and coordinating system for this life power.

We recognize that there may exist an internal interference with the flow of this life power.

We recognize that proper coordination, repair, healing, locomotion, motivation, and genetic potential are not expressed when this life power is blocked, and that tension in our nervous system blocks this power.

We recognize that network spinal analysis entrainments release the tension in the nervous system, enhancing its capacity to carry this life power.

We recognize that *everyone*, in spite of his or her symptoms or ailments, can benefit from a nervous system that is more flexible, elastic, and able to grow and develop without the interfering effect of adverse mechanical spinal cord tension.

We recognize that symptoms are not necessarily a sign of illness. They also serve to alert you of the need for change. We recognize that although an illness may be *incurable*, the individual in whom the illness resides is often not.

We recognize the specific location of symptoms does not tell the specific location of spinal cord tension, and the severity of symptoms is not consistently related to the severity of such tension.

We do not name or treat symptoms, conditions, or ailments. We do not state directly or imply that any specific entrainment or series of entrainments will affect any condition you may have.

We recognize there are many professions that attempt to make you more comfortable by treating your conditions.

If you have a symptom, condition, or ailment about which you are concerned, we suggest you consult with a disease or symptom care specialist. We may be able to assist you with a referral.

We understand the purpose of the entrainment is to allow the internal wisdom of your body to fully express itself. Drugs, such as tranquilizers, muscle relaxants, anti-inflammatory compounds, beta-blockers, hypertensive medications, and pain blocking compounds, by their very intent, interfere with the normal function of your nervous system.

We will not venture into the practice of medicine by telling you to take or not to take any specific treatment. We feel it is your responsibility to speak with your physician to determine the objective of ingesting any drug or receiving any treatment, and determine if this is consistent with your desire for healing and wellness. As the entrainments help your body normalize, the body's chemistry changes. You should seek the physician's consult in potential reduction of medication levels. Naturally, medication levels for a non-flexible body, stuck in sickness, are not the same for a body on the road to wellness.

We choose to help each individual member of this practice achieve a greater level of wellness, elasticity, personal growth and development, by initiating the process of reduction of spinal cord tension.

By my signature below, I acknowledge I have reviewed the above statements and understand the content. I choose to receive Network Spinal Analysis care to enhance my body's ability to heal. Although symptoms and ailments often undergo marked changes with care, I understand the entrainments I receive in this office are not a treatment of any condition, symptom, or ailment other than spinal cord tension. I also understand I am not being discouraged from seeking the services of any other type of practitioner.

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PRINTED NAME

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DATE

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SIGNATURE

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Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Female  Male Height \_\_\_\_\_ Weight \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell) \_\_\_\_\_ E-mail address \_\_\_\_\_

Marital Status M S D W Children's Names \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Please complete this general health history survey. This information provides your doctor with important information to better understand your history, your immediate and long-term goals, and any compromise in your health-related quality of life, or wellness.

1. Do you have any current health concerns? .....  Yes  No

Please describe your current health concern(s) and what treatment(s) you have received, or, what you have done (if anything) regarding these concerns.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please grade the effect these current health concerns have on your quality of life.

0 = NONE    1 = SLIGHT    2 = MODERATE    3 = EXTREME

	0	1	2	3		0	1	2	3
Concern about a particular symptom/condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overall concern about health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on work .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effect on recreation/play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on rest/sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effect on social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effect on sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on exercise .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effect on love life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on eating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effect on ability to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

Has any other family member had the same or similar concerns?.....  Yes  No

If yes, what did that person do about them? \_\_\_\_\_

2. Have you ever injured your spine, head, neck, back, or hips?.....  Yes  No

Date of **most significant** injury: \_\_\_\_\_ What happened? \_\_\_\_\_

Date of **most recent** injury: \_\_\_\_\_ What happened? \_\_\_\_\_

3. Please check all that apply:
- I feel helpless; nothing works.
  - I feel this is a terrible thing that has happened to me.
  - I feel this is a terrible thing that has happened to me, and I hope you can fix it.
  - I feel this is a pattern that has happened to me before; it is back again.
  - I feel this is a pattern that has happened to me before; I feel stuck.
  - I feel there is a message my body is giving me.
  - I deserve more than this.
  - I am going to move past this health concern by having the doctor treat it.
  - I am going to move past this health concern by becoming healthier.
  - I don't like what I feel, but I am O.K. with feeling what I am feeling because it may be necessary for me to heal.
  - I am ready to make changes in my life to become healthier and more whole.
  - I have had enough and it is time to be well.
  - I don't know how I feel about how I feel. I am too preoccupied with my present situation.

4. Please describe your anticipated *immediate* results; what you hope to benefit from chiropractic care in the short term:

A = VERY IMPORTANT      B = IMPORTANT      C = NOT SO IMPORTANT      D = DOES NOT APPLY

	A	B	C	D		A	B	C	D
Improvement with physical symptoms .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Improvement with reactions/responses to stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall improvement of my quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Improvement with emotional/mental symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement in enjoyment of life and the ability to make constructive choices for myself .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Please describe your anticipated *long-term* results; what you hope to benefit from chiropractic care in the long term:

A = VERY IMPORTANT      B = IMPORTANT      C = NOT SO IMPORTANT      D = DOES NOT APPLY

	A	B	C	D		A	B	C	D
Improvement with physical symptoms .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Improvement with reactions/responses to stress .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall improvement of my quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Improvement with emotional/mental symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement in enjoyment of life and the ability to make constructive choices for myself .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Has your spine ever been professionally adjusted? .....  Yes    No

By whom and when? \_\_\_\_\_

Why? \_\_\_\_\_

What results did you receive from that treatment? \_\_\_\_\_

Are you still receiving adjustments?  Yes    No \_\_\_\_\_

Were you pleased with the treatment?  Yes    No \_\_\_\_\_

Does your family receive chiropractic care? Please explain.  Yes    No \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Do you consult with a physician for other than routine evaluations? .....  Yes    No

8. When was your last visit to a physician, and what was the reason for the visit? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was done or suggested? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Please list medications (prescription or non-prescription) you have taken within the past 60 days: \_\_\_\_\_  
\_\_\_\_\_

10. Have you taken other medications for a period of more than three months in the past? \_\_\_\_\_  Yes  No  
If so, what medication? \_\_\_\_\_

11. What was the reason for taking this medication? \_\_\_\_\_  
\_\_\_\_\_

12. Have you had any x-rays, CT scans, or MRI imaging of your spine, head, neck, back, or hips?.....  Yes  No

13. If yes, when and why? \_\_\_\_\_  
\_\_\_\_\_

What were you told about them? \_\_\_\_\_  
\_\_\_\_\_

Where are these films now? \_\_\_\_\_

14. Have you had any surgery?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

15. Have you broken any bones, or significantly sprained a part of your body?  Yes  No If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

16. Please list any herbs, nutritional supplements, or natural remedies you take regularly. \_\_\_\_\_  
\_\_\_\_\_

17. Please rate your current stress level for each of these areas in order of the intensity you feel.

0 = NO AWARENESS OF STRESS    1 = SLIGHTLY STRESSFUL  
2 = MODERATELY STRESSFUL    3 = EXTREMELY STRESSFUL

	0	1	2	3
Physical stress, trauma, abuse, including: falls, accidents, injuries, and impacts .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/mental stress; including loss of loved ones, rapid change in life situation, trauma, abuse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical stress, includes drugs, smoke, fumes, food additives.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Have you had a work related injury?  Yes  No Please explain: \_\_\_\_\_  
\_\_\_\_\_

*Meeting with you to explain the objectives at each Level of Care, reporting our findings, and communicating this to you, is very important to us. The answers you give to the following questions help us maximize communication so you can fully participate in the program of care, as well as the educational process focused on your spine, nervous system, your health, and your wellness.*

19. When communicating to you about your spine, nervous system, health, and wellness, do you prefer that we:

- Show you in written form the clinical findings and let you see the changes you are making?
- Speak with you about the clinical findings and tell you about the changes you are making?
- Let you get a sense of the clinical work and help you feel the difference in your body?

20. Which statement most accurately represents your preference?

I feel more comfortable with contrasting differences between things such as:

“This was our starting point, and this is what changed since that time.”

I prefer to find similarities in things such as:

“This is what we attempted to achieve, and these are the things that changed.”

21. Who referred you to this office, and how did you hear about the services we offer? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

22. Is there some aspect of your health or your life that very much pleases you, brings you joy, or helps you feel better about yourself, or, that helps you forget or minimizes any health concerns? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Is there anything else that may help us to understand you, your history, or your professional needs, that has not been discussed in this questionnaire? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for choosing our Network Spinal Analysis office. We look forward to helping you have successful experiences as you develop a healthy spine and nervous system. We are excited about the possibility of assisting you in achieving greater health and wellness.

I fully understand and agree that all services rendered are charged directly to me, and I am directly responsible for payment at the time services are rendered. In the case of any dispute regarding services, I agree to submit said dispute to arbitration.

Patient or responsible party's signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's notes: \_\_\_\_\_

## **Directions to our Office**

**4405 Manchester Avenue; Suite 108  
Encinitas, CA 92024**

### **From the South:**

Take I-5 North to Manchester Avenue Exit, turn East (or Left).  
Follow Manchester Avenue as it turns to the right. Turn left into the last parking lot before Rite-Aid (just before Manchester crosses Encinitas Boulevard).

Our office is located in the back building on the right, ground floor.

### **From the North:**

Take I-5 South to Encinitas Boulevard. Drive for about 3 miles, then turn right onto Manchester Avenue. Turn right into the parking lot just after Rite Aid.

Our office is located in the back building on the right, ground floor.

If you have any questions, please call us at 760.889.6096