Body Awakening Chiropractic

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 Consent to Treat fom.
- ✓ Directions to our 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 Consent to Treat form.
- ❒ 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 tissue.

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.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/ or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my pres ent condition and for any future conditions(s) for which I seek treatment.

Dr. Iwona Szpiech, D.C.

_____	_____	_____
Patient Printed Name	**Signature**	**Date**

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

Body Awakening Chiropractic

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.

No Mark = NONE 1 = SLIGHT 2 = MODERATE 3 = EXTREME

	1	2	3		1	2	3
Concern about a particular symptom/condition……	❒	❒	❒	Overall concern about health…….	❒	❒	❒
Effect on work ……	❒	❒	❒	Effect on recreation/play…….	❒	❒	❒
Effect on rest/sleep……	❒	❒	❒	Effect on social life……	❒	❒	❒
Effect on walking……	❒	❒	❒	Effect on sitting……..	❒	❒	❒
Effect on exercise ……	❒	❒	❒	Effect on love life…….	❒	❒	❒
Effect on eating……	❒	❒	❒	Effect on ability to work…….	❒	❒	❒

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 ……..	❒	❒	❒	❒	Improvement with reactions/responses to stress..	❒	❒	❒	❒
Overall improvement of my quality of life..	❒	❒	❒	❒	Improvement with emotional/mental symptoms…	❒	❒	❒	❒
Improvement in enjoyment of life and the ability to make constructive choices for myself ……..						❒	❒	❒	❒

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 ……	❒	❒	❒	❒	Improvement with reactions/responses to stress…	❒	❒	❒	❒
Overall improvement of my quality of life	❒	❒	❒	❒	Improvement with emotional/mental symptoms…..	❒	❒	❒	❒
Improvement in enjoyment of life and the ability to make constructive choices for myself……						❒	❒	❒	❒

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 ……	❒	❒	❒	❒
Emotional/mental stress; including loss of loved ones, rapid change in life situation, trauma, abuse	❒	❒	❒	❒
Chemical stress, includes drugs, smoke, fumes, food additives.....	❒	❒	❒	❒

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:_____

_____

_____

_____

_____

_____

_____