



.....Welcome

Personal History

Date: _____

Name: _____ Address: _____
City: _____ State: _____ Zip/Postal Code: _____
Home Phone: _____ Birth Date: _____ Age: _____
Cell Phone: _____ Sex: Male Female
Social Security # _____ Check One: Married Single Divorced Widowed
E-mail Address: _____
Business Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____
Spouse's Employer _____ Type of Work _____
Names and Ages of Children: _____
How were you referred to our office? Website Facebook Blog Person: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who is responsible for your bill, Self Worker's Comp. Auto Insurance Medicare Health Insurance

Current Health History

Purpose of this Appointment _____
Other Doctors seen for this condition: Yes No Who? _____
Type of Treatment: _____ Results: _____
Intensity Level, On a scale of 1 to 10 (1 = none, 10 = extreme) _____ Since problem started, it is: Same Getting Better Getting Worse
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other _____
Date of Accident: _____ Time of Accident _____
What, if anything, makes the problem feel better? _____
Drugs You Take Now: Anti-Depressants Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Blood Thinners
 Other _____
Do You Wear a Shoe Lift / Insert? Yes No
Do You Suffer From Any Other Condition *Other Than* That Which You Are Now Consulting Us? _____
Name of Your Primary Care Provider? _____ Office Phone _____

Past Health History

Please Check and Describe:
Surgery / Operations: Appendectomy Tonsillectomy Gall Bladder Ear Tubes/Adenoids Broken Bones
 Back / Neck Surgery Other _____
Accidents or Falls: _____
Hospitalizations (Other Than Above): _____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Lifestyle

Do you exercise? [] Yes [] No How often? (Circle) 1X 2X 3X 4X 5X /per week Other: _____

What activities? [] Running [] Jogging [] Weight Training [] Cycling [] Yoga [] Pilates [] Swimming
[] Other _____

Do you smoke? [] Yes [] No How much? _____

Do you drink alcohol? [] Yes [] No How much / week? _____

Do you drink coffee? [] Yes [] No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Health Conditions

Accumulation of Physical, Chemical and Emotional Stressors lead to Nerve Stress on your entire body. This nerve stress leads to a body that has challenges adapting, healing, functioning and feeling good. Slips, falls, accidents and abnormal postural habits lead to spinal misalignments which cause undetected nerve damage. Our food choices and prolonged uses of medications lead to toxicity and chronic emotional stress leads to hormone imbalances (adrenaline/cortisol). It has been extensively documented that accumulated nerve stress will weaken and distort the overall structure of your spine and will negatively impact overall organ function and health. The areas of nerve stress will determine the organs affected and its affect on your body's health.

1. Accumulated nerve stress in your neck (Cervical Spine) leads to the following. In the past or presently, have you experienced:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Energy / Fatigue | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pain into Shoulders/Arms/Hands | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Weakness in Grip |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> TMJ Pain / Clicking | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Coldness in Hands | <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Recurrent Colds/Flu | <input type="checkbox"/> Hearing Disturbances | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Ear Infections |

2. Accumulated nerve stress at your mid/upper back (Thoracic Spine) leads to the following. In the past or presently, have you experienced:

- | | | |
|---|---|--|
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tired / Irritable after eating | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Heart Attacks/Angina |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Coldness in Hands | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Recurrent Colds/Flu | <input type="checkbox"/> Hearing Disturbances |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Allergies/Hay Fever |
| <input type="checkbox"/> Ear Infections | | |

3. Accumulated nerve stress at your lower back (Lumbar Spine) leads to the following. In the past or presently, have you experienced:

- | | | |
|--|--|--|
| <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Coldness in your legs/feet |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Bed Wetting |

Do Not Write Below This Line

Chiropractic/Nutritional Analysis

Patient Accepted: [] Yes [] No [] Referred

Doctor's Signature



Your Goals

-(Patient Cont'd)-

On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = _____ Occupational stress: _____

Scale = _____ Personal stress: _____

On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating _____ Exercise _____ Sleep _____ General Health _____ Wellness lifestyle _____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals:

Wellness Goals		
Be Fit. <i>(Physical)</i>	Eat Right. <i>(Nutritional)</i>	Think Well. <i>(Psychological)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Consent to Care

I do hereby authorize the doctors of The Gallagher Wellness Centre to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow 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, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and 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, disk 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, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, 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 present condition and for any future condition(s) for which I seek treatment.

Signature _____ Date _____

(If under age 18) Parent's signature

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature _____ Date _____

(If under age 18) Parent's signature

