Empowered Health
Chiropractic & Wellness

Inspiring a healthy community, one family at a time

Patient Information

First Name: Last Name: Date:

SSN: DOB: Sex: ◯M ◯F

Significant Other's Name: Kid's Names and Ages:

Street Address:

City, State, Zip:

Email: Cell Phone: Other Phone:

Your Employer: Occupation:

How did you hear about us?

Name of Primary Care Doctor: Phone:

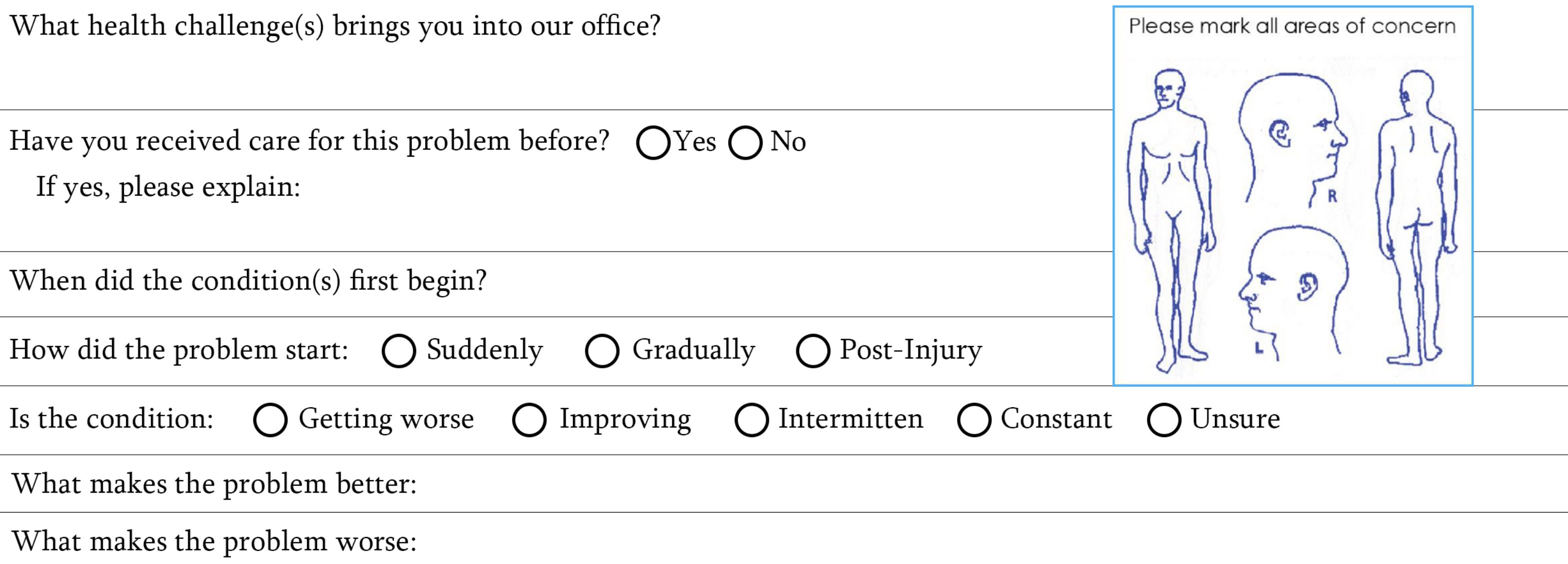
Date and reason for your last doctor visit:

Are you receiving care from any other health professionals? ◯Yes ◯No

If yes, please name them and their specialty:

Please note any significant family medical history:

Current health Challenges



What health challenge(s) brings you into our office?

Have you received care for this problem before? ◯Yes ◯No

If yes, please explain:

When did the condition(s) first begin?

How did the problem start: ◯ Suddenly ◯ Gradually ◯ Post-Injury

Please mark all areas of concern

Is the condition: ◯ Getting worse ◯ Improving ◯ Intermitten ◯ Constant ◯ Unsure

What makes the problem better:

What makes the problem worse:

Health goals

Your top three health goals:

1: ______________ 2: ______________ 3: ______________

Chiropractic History

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you been to a chiropractor before? ◯ Yes ◯ No If yes, what is their name?

Do you have any health concerns for other family members today?

Trauma: Physical Injutry History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or childhood sports? ◯ Yes ◯ No If yes, list major injuries:

Excercise frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
Type of exercise?

How do you normally sleep? ◯ Back ◯ Stomach ◯ Side

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

How many hours per day do you typically spend sitting at a desk, computer, tablet or phone?

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High
Alcohol	1	2	3	4	5
Water	1	2	3	4	5
Sugar	1	2	3	4	5
Dairy	1	2	3	4	5
Gluten	1	2	3	4	5

	None		Moderate		High
Processed foods	1	2	3	4	5
Artificial sweetners	1	2	3	4	5
Sugary drinks	1	2	3	4	5
Cigarettes	1	2	3	4	5
Recreational drugs	1	2	3	4	5

Please list any drugs/medications/supplements/herbs that you are taking and why:

Thoughts: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate		High
Home	1	2	3	4	5
Work	1	2	3	4	5
Life	1	2	3	4	5

	None		Moderate		High
Money	1	2	3	4	5
Health	1	2	3	4	5
Family	1	2	3	4	5

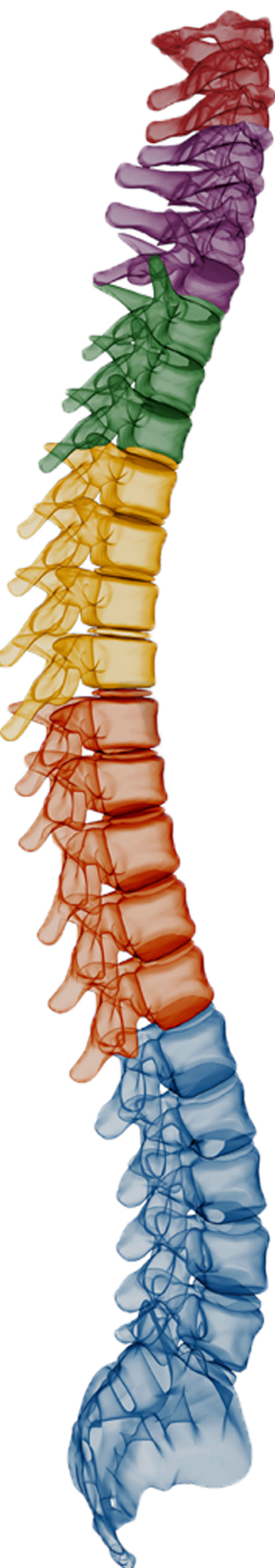
Acknowledgement & Consent

Patient Name: Signature: Date:

Review of Systems

The nervous system controls and coordinates ALL organs and structures of the human body

Please check the corresponding boxes for each symptom or condition you have experienced - inlcuding both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (Past / Present)	SYMPTOMS (Past / Present)
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	Colic & Excessive Crying Ear & Sinus Infections Allergies & Congestion Immune Deficiency Headaches & Migraines Vertigo & Dizziness Sore Throat & Strep Swollen Tonsils & Adenoids Vision & Hearing Issues Low Energy & Fatigue Sore Throat & Strep Pain, Numbness & Tingling in Arm/Hands	Epilepsy & Seizures Sensory & Spectrum ADD / ADHD Focus & Memory Issues Anxiety & Stress Balance & Coordination Speech Issues TMJ / Jaw Pain Depression Stiff Neck & Shoulder High Blood Pressure Poor Metabolism & Weight Control
Upper Thoracic	• Upper GI • Respiratory System • Cardiac Function	Reflux / GERD Chronic Colds & Coughs Functional Heart Conditions	Bronchitis & Pneumonia Asthma
Mid Thoracic	• Major Digestive Center • Detox & Immunity	Gallbladder Pain / Issues Jaundice Fever	Indigestion & Heartburn Stomach Pains & Ulcers Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	Behavior Issues Hyperactivity Chronic Fatigue Chronic Stress	Allergies & Eczema Skin Conditions / Rash Kidney Problems Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune system • Major Hormone Control	Constipation Chrohn's, Colitis & IBS Diarrhea Bed-wetting Bladder & Urination Issues Cramps & Menstrual Issues Cysts & Endometriosis Infertility Impotency	Sciatica & Radiating Pain Lumbopelvic / SI Pain Hamstring tightness Disc Degeneration Leg Weakness & Cramps Poor Circulation Low Back Pain Knee, Ankle, Foot Pain Gluten & Casein Intolerance

Patient Name: ______________________ Date: __________

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Consent Form

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, and any other associated procedures on me by Dr. Christelle Vang of Empowered Health Chiropractic & Wellness.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's *nothing* we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the circle that applies to you:

☐ **Yes!** You can use my picture on the **Empowered Health Chiropractic website, marketing material** and **Facebook** page.
☐ No thanks! I'll pass for now.

____
Printed name of patient

____
Signature of patient — Date

____
Signature of representative (if patient is a minor or handicapped) — Date