



TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS “WE,” “OUR” AND/OR “US” REFERS TO THE LEGAL OWNER AND OPERATOR OF THIS THE JOINT CLINIC LOCATION.

EXPLANATION OF SERVICES

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body’s ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don’t do:

WHAT WE DO

- We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed doctors of chiropractic to improve motion of the body’s spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON’T DO / LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.
- We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment or administer physiotherapies such as laser, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.
- In the doctor’s professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

At the patient’s discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

All questions regarding the doctor’s objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location or any other clinic under The Joint Chiropractic (“The Joint”) trade name based upon these guidelines.



(Patient Signature) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read
(Parent or Legal Guardian) (Child/(ren) Name)

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.



(Parent or Legal Guardian Signature) (Date)



TERMS OF ACCEPTANCE MEDICARE ELIGIBLE PATIENTS

AS USED IN THESE DOCUMENTS, THE TERMS “WE,” “OUR” AND/OR “US” REFERS TO THE LEGAL OWNER AND OPERATOR OF THIS THE JOINT CLINIC LOCATION.

EXPLANATION OF SERVICES

When a Medicare Eligible Patient seeks chiropractic health care here, it is essential for the patient to understand the services we provide.

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body’s ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

We ONLY provide maintenance care for Medicare Eligible Patients. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don’t do:

WHAT WE DO

- We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed doctors of chiropractic to improve motion of the body’s spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON’T DO / LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.
- We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment or administer physiotherapies such as laser, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.
- In the doctor’s professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

At the patient’s discretion, payment options are available upon request after the Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

All questions regarding the doctor’s objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location or any other clinic under The Joint Chiropractic (“The Joint”) trade name based upon these guidelines.



(Patient Signature) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD OR PATIENT

I, _____ of _____ have read
(Parent or Legal Guardian) (Child or Patient Name)

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.



(Parent or Legal Guardian Signature) (Date)



ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN) MEDICARE ELIGIBLE PATIENTS

Notifier: The Joint Chiropractic - Hilton Village
6107 N. Scottsdale Road, Suite C-102, Scottsdale, AZ 85250
Phone: (480) 245-7844

→ **Patient Name:** _____
(Patient Name Printed)

NOTE: If Medicare doesn't pay for chiropractic maintenance care below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the chiropractic maintenance care below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay: Spinal physical or manipulative treatment performed for Maintenance Care rather than restorative care is not a payable service by Medicare.	Estimated Cost per Visit: \$10 - \$45
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WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the chiropractic maintenance care listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS Check only one box. We cannot choose an option for you.

Option 1: I want the chiropractic maintenance care listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. By selecting this option we will refer you to another provider.

Option 2: I want the chiropractic maintenance care listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

Option 3: I don't want the chiropractic maintenance care listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.** By selecting this option we will refer you to another provider.

Additional Information:

This ABN form is only good for up to one (1) year.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

→ _____
(Patient or Legal Guardian Signature) (Date)

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



PATIENT INFORMATION

Patient ID (Keytag Number) _____

First Name _____ Last Name _____

Gender M F Date of Birth _____ / _____ / _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ W H C 2nd Phone _____ W H C

Email _____

What is your preferred method of communication? Phone Text Email

Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____ W H C

Are you Medicare Eligible? Yes No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? Yes No

Will you use this location from your: Home Office or Both?

Approximately, how far did you travel to get here today? 0-3 miles 3-5 miles 5-10 miles 10+ miles

Approximately, how long did it take you to get here today? 0-5 mins. 6-10 mins. 11-15 mins. 15+ mins.

How did you first hear about The Joint Chiropractic?

If you were referred by someone please tell us who so we may thank them.

 _____
(Patient or Legal Guardian Signature)

(Date)

PATIENT HISTORY

Name _____ Age _____ Date of Birth ____/____/____ Gender M F
 Height _____ ft. _____ in. Weight _____ lbs. Occupation _____ For how long? ____yrs. ____mos.

1. Have you had chiropractic care before? Yes No If yes, how recently? _____

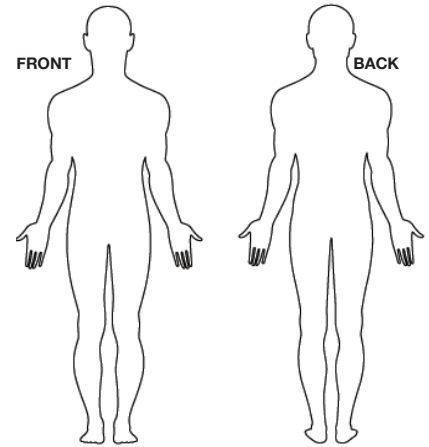
2. Reason for today's visit:
 Pain Discomfort Stiffness Maintenance Care Recent Injury Previous Injury Other _____

3a. When did your complaint(s) first begin? _____ 3b. Today, is the condition: Same Better Worse

Explain what helps and/or worsens the condition: _____

4. Where is/are your area(s) of complaint today? Check all that apply	Rate pain and discomfort between 1-10 1 = minimal 10 = severe	Check off the type of Complaint							Frequency	
		Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed/swollen	Constant	Intermittent
Headache/Migraine										
Neck										
Shoulder(s)										
Arm(s)										
Elbow(s)										
Wrist(s)										
Upper Back										
Middle Back										
Lower Back										
Hip(s)										
Sciatica										
Knee(s)										
Ankle(s)										
Other										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



6. Have you experienced this/these complaint(s) before? Yes No
 if yes, when? _____

7. Are you pregnant? Yes No N/A If yes, how many weeks? _____

8. Are you currently experiencing any of the following:
 Nausea or vomiting Rapid eye movement Numbness on one side of the face or body Fainting or lightheadedness Dizziness
 Difficulty walking Difficulty speaking Headache or neck pain Difficulty swallowing Double vision
 (If yes to any, please describe) _____

9. Current prescriptions or over-the-counter medications: _____

For Clinic Use Only: BP: _____ / _____

PAST HISTORY: MUSCULOSKELETAL CONDITIONS (please check all that apply)	OTHER CONDITIONS
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Cancer
<input type="checkbox"/> Neck Pain/Discomfort	<input type="checkbox"/> Tumors
<input type="checkbox"/> Shoulder Pain/Discomfort	<input type="checkbox"/> Stroke
<input type="checkbox"/> Upper Back Pain/Discomfort	<input type="checkbox"/> Seizure Disorders
<input type="checkbox"/> Middle Back Pain/Discomfort	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low Back Pain/Discomfort	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Inflammation/Swelling; where _____	<input type="checkbox"/> Allergies
<input type="checkbox"/> Hip Pain/Discomfort	<input type="checkbox"/> Other _____
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Elbow Pain/Discomfort	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Wrist Pain/Discomfort	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Knee Pain/Discomfort	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Ankle Pain/Discomfort	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hernia
<input type="checkbox"/> Fused/Fixated Joints	
<input type="checkbox"/> Herniated Disc	
<input type="checkbox"/> Joint Replacement	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Osteopenia	

10. Indicate if you have experienced any of the following and mark how recently.
 Surgeries? Yes No → Less than 1 month 1-6 months 6-12 months More than 12 months ____ yrs.
 Accidents/Broken Bones? Yes No → Less than 1 month 1-6 months 6-12 months More than 12 months ____ yrs.
 Hospitalizations? Yes No → Less than 1 month 1-6 months 6-12 months More than 12 months ____ yrs.
 If yes to any, list and describe _____

11. Family Health History: (check all that apply) Cancer Tumors Stroke Seizures Diabetes High Blood Pressure Heart Disease

→ _____ (Patient or Legal Guardian Signature) _____ (Date)



INFORMED CONSENT

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body’s spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

- 1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
- 2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
- 3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from THE JOINT.

Dated this _____ day of _____ 20_____

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis.*

***In California, please initial after reading the statement, above. Patient initials _____ Doctor initials _____**

(Patient Printed Name)

→ _____
(Patient or Legal Guardian Signature)

(Date)

(Witness / Employee Signature)

(Date)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY US, ANY THE JOINT CLINIC, AND THE JOINT CORP. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact your local facility.

Who Will Follow This Notice?

1. Us, all The Joint clinics, and The Joint Corp.;
2. Doctors of Chiropractic who provide services to you at any The Joint clinic; and
3. All employees and subcontractors of all The Joint clinics and The Joint Corp.

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

1. Basis for planning your treatment;
2. Means of communication for or between The Joint clinic doctors and staff, the doctors and staff of other clinics operating under The Joint name, The Joint Corp. and your other health care providers, if any, that you wish us to share them with; and a
3. Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as “medical information”). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES

We are required by law to:

1. Maintain the privacy and security of your medical information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice; and
4. Notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic or any other THE JOINT clinic where you seek treatment. For example, we may share your information with your primary care physician or other specialists upon request.
2. **For Payment.** We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
3. **For Health Care Operations.** We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devices will have a notice posted at the clinic informing you of the use of such devices.
4. **For Contacting You.** We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.
5. **Appointment Reminders.** We may use and disclose medical information to remind you of an appointment, if applicable.
6. **As Required by Law.** We will disclose medical information about you when required to do so by federal or state laws or regulations.
7. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
8. **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
9. **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.
10. **Electronic Disclosure.** We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically.



NOTICE OF PRIVACY PRACTICES CONTINUED

DISCLOSURES REQUIRING AUTHORIZATION

1. **Marketing.** Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

- 1. **Right to Inspect and Copy.** The right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to us. You can also ask to see or get an electronic copy of health information we have about you. Ask us how to do this.
- 2. **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us or The Joint Corp. To request an amendment, your request must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by us or The Joint Corp.;
 - Is not part of the information which you would be permitted to inspect and copy; or
 - Is accurate and complete.
- 3. **Right to an Accounting of Disclosures.** To request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.
- 4. **Right to Request Restrictions.** To request a restriction or limitation on the medical information we, other The Joint clinics, or The Joint Corp. uses or discloses about you for treatment OR payment. You also have the right to request a limit on the medical information we, any The Joint clinic, or The Joint Corp. discloses about you to someone who is involved in your care or the payment for your care. Neither we, nor any The Joint clinic or The Joint Corp. are required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.
- 5. **Right to Revoke an Authorization.** There are certain types of uses or disclosures that require your express authorization. For example, we, other The Joint clinics, and The Joint Corp. may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.
- 6. **Right to Receive a Copy of this Document.** You have a right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting us.

I understand and agree to the patient privacy notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

(Patient Printed Name)

→ _____
(Patient or Legal Guardian Signature)

(Date)

(Witness / Employee Signature)

(Date)

PATIENT ACTIVITY ASSESSMENT FORM

Name _____ Today's Date ____/____/____

Occupation _____ Age _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

STANDING OR SITTING

<p>Do you primarily stand or sit at work: <input type="checkbox"/> Stand <input type="checkbox"/> Sit</p> <p>Approximately how many hours per week:</p> <p><input type="checkbox"/> 0-20 hours <input type="checkbox"/> 20-40 hours <input type="checkbox"/> 40+ hours</p> <p>Are those hours primarily spent:</p> <p>On the phone:</p> <p><input type="checkbox"/> Cell <input type="checkbox"/> Desktop Phone <input type="checkbox"/> Headset <input type="checkbox"/> No headset</p> <p>Typing at a keyboard:</p> <p><input type="checkbox"/> Laptop <input type="checkbox"/> Desktop computer</p> <p><input type="checkbox"/> Other: _____</p>	<p>What is your most common posture:</p> <p><input type="checkbox"/> Sitting upright <input type="checkbox"/> Slouched <input type="checkbox"/> Crossed legs <input type="checkbox"/> Stand</p> <p>Does your work require you to:</p> <p><input type="checkbox"/> Bend <input type="checkbox"/> Twist <input type="checkbox"/> Lift <input type="checkbox"/> Carry <input type="checkbox"/> N/A</p> <p>What type of shoes do you wear on a regular basis:</p> <p><input type="checkbox"/> Dress <input type="checkbox"/> Heels <input type="checkbox"/> Running <input type="checkbox"/> Boots <input type="checkbox"/> Athletic <input type="checkbox"/> Sandals</p> <p><input type="checkbox"/> Other: _____</p> <p>Do you wear orthotics: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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SLEEPING

<p>What type of bed do you sleep in:</p> <p><input type="checkbox"/> Memory foam <input type="checkbox"/> Adjustable firmness <input type="checkbox"/> Inner spring</p> <p><input type="checkbox"/> Other: _____</p> <p>How many hours of sleep do you get per night: <input type="checkbox"/> 8 hrs or less <input type="checkbox"/> More than 8 hrs</p>	<p>What position do you sleep in: <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/> Side <input type="checkbox"/> All</p> <p>Do you regularly wake up with any back stiffness: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you regularly wake up with any neck stiffness: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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BODY STRESSORS

<p>Do your daily activities require you to lift and/or carry objects: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often:</p> <p><input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constant</p> <p>If yes, approximately, how heavy:</p> <p><input type="checkbox"/> 10 lbs or less <input type="checkbox"/> 10-30 lbs <input type="checkbox"/> More than 30 lbs.</p> <p>Do you exercise: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, approximately how many days per week:</p> <p><input type="checkbox"/> 0-1 day(s) <input type="checkbox"/> 1-3 days <input type="checkbox"/> 3+ days</p> <p>Type(s) of exercise:</p> <p>Weight training:</p> <p><input type="checkbox"/> Free weights <input type="checkbox"/> Machines <input type="checkbox"/> Other: _____</p>	<p>Cardio training:</p> <p><input type="checkbox"/> Elliptical <input type="checkbox"/> Treadmill/Running <input type="checkbox"/> Other: _____</p> <p>Do you participate in sports: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate all that apply:</p> <p><input type="checkbox"/> Football <input type="checkbox"/> Basketball <input type="checkbox"/> Skiing <input type="checkbox"/> Body building <input type="checkbox"/> Soccer</p> <p><input type="checkbox"/> Tennis <input type="checkbox"/> Walking/Hiking <input type="checkbox"/> Volleyball <input type="checkbox"/> Racquetball <input type="checkbox"/> Yoga</p> <p><input type="checkbox"/> Dancing <input type="checkbox"/> Cycling/biking <input type="checkbox"/> Golf</p> <p><input type="checkbox"/> Other: _____</p> <p>Do you have children at home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many? <input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> More than 3 _____</p> <p>Do any of your children require you to carry them? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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CHIROPRACTIC ACTIVITY ASSESSMENT

<p>Did You Know: the absence of pain is not an indication of health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did You Know: pain has a cause and many times that cause begins in the spine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did You Know: over-the-counter pain medications and / or prescriptions may only mask the pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Did You Know: decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did You Know: the health benefits of routine chiropractic care may include any of the following: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1) Improved nerve communication</td> <td style="width: 50%;">5) Improved physical performance</td> </tr> <tr> <td>2) Improved joint motion</td> <td>6) Improved posture</td> </tr> <tr> <td>3) Improved joint coordination</td> <td>7) Increased daily activity</td> </tr> <tr> <td>4) Improved physical function</td> <td>8) Provide pain and stress relief</td> </tr> </table>	1) Improved nerve communication	5) Improved physical performance	2) Improved joint motion	6) Improved posture	3) Improved joint coordination	7) Increased daily activity	4) Improved physical function	8) Provide pain and stress relief
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Our mission is simple: "To improve quality of life through routine and affordable chiropractic care." We congratulate you on your decision to invest in yourself and commitment towards achieving improved joint function and healthier, more active lifestyle. Our journey towards that goal begins here.