Today's Date_____

LIVE FREE CHIROPRACTIC HEALTH PROFILE

Name_____Birth Date____/____/____ Age_____ Male/Female

Address_____ City_____State_____ Zip_____

Phone: Home_____ Cell_____ Cell Phone Provider_____

Email Address_____If Under 18: Parent's Names_____

Occupation_____Employer's Name_____

Single/Married/Divorced/Widowed Spouse/Significant Other's Name_____

Number of Children_____ Are you Pregnant? Y / N Children's Names, Ages & Gender_____

_____

Whom may we Thank for referring you?_____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to Severity	Rate the Severity 1=Mild 10=Unbearable	When did this episode Start?	Did the problem begin with an injury?	How often does this bother you?	How long does each episode last?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____MEDICAL DOCTOR?_____OTHER?_____

WHO/WHEN?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

ACID REFLUX	*CANCER*	*HEADACHES*	*LOW BACK PAIN*	*PREGNANCY ISSUES*
ADD/ADHD	*CHEST PAIN*	*HEART PROBLEMS*	*LUPUS*	*RHEUMATOID ARTHRITIS*
ALLERGIES	*CHRONIC FATIGUE*	*HIP PAIN*	*MENSTRUAL ISSUES*	*SCIATICA*
ANXIETY	*COLIC*	*HYPERTENSION*	*MID BACK PAIN*	*SHOULDER PAIN*
ARM PAIN	*CONSTIPATION*	*IMMUNE DEFICIENCY*	*NAUSEA*	*SINUS INFECTIONS*
ARTHRITIS	*DEPRESSION*	*INFERTILITY*	*NECK PAIN*	*SLEEP ISSUES*
ASTHMA	*DISC PROBLEM*	*IRRITABLE BOWEL*	*NERVOUSNESS*	*STOMACH ISSUES*
AUTISM	*DIZZINESS*	*KIDNEY PROBLEMS*	*NUMBNESS IN ARMS*	*THYROID PROBLEMS*
AUTOIMMUNE	*EAR INFECTIONS*	*KNEE PAIN*	*NUMBNESS IN FEET*	*TINNITUS*
BEDWETTING	*EPILEPSY*	*LEG PAIN*	*NUMBNESS IN HAND*	*TMJ*
BLADDER PROBLEMS	*FIBROMYALGIA*	*LIVER DISEASE*	*NUMBNESS IN LEGS*	*VERTIGO*
				OTHER: _____

PRINT YOUR NAME:_____

CIRCLE* *ANY PROBLEM YOU HAVE NOW OR HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS:_____

_____

LIST ALL OVER-THE-COUNTER AND PRESCRIPTION MEDICATIONS YOU ARE ON: _____

_____

WHEN WAS YOUR LAST AUTOMOBILE ACCIDENT?_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IS YES, PLEASE NAME DOCTOR AND DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA?_____

_____

ADDITIONAL CONCERNS_____

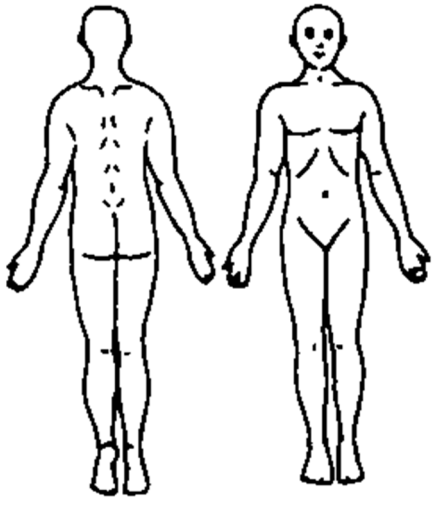
Social History

1. SMOKING: ☐ Cigars ☐ Pipe ☐ Cigarettes → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. EXERCISE: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

***PLEASE MARK** THE AREAS ON THE DIAGRAM WITH THE FOLLOWING **LETTERS** TO DESCRIBE YOUR SYMPTOMS:

R = Radiating **B = B**urning **D = D**ull **A =** Aching
N = Numbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Practice Member Information
(Must be Completed Before Services Can Be Rendered)

NAME_____
FIRST MIDDLE LAST

PHONE: Home_____Cell_____Work_____

SOCIAL SECURITY NUMBER_____ **MARITAL STATUS**_____

DATE OF BIRTH_____

EMERGENCY CONTACT_____**PHONE #**_____

NAME OF PRIMARY INSURANCE COMPANY:_____

NAME OF POLICY HOLDER (If different from above):_____

POLICY HOLDER DATE OF BIRTH_____

DO YOU HAVE A HSA/FSA? (Health/Flexible Savings Account) ☐ **YES** ☐ **NO**

NAME OF SECONDARY INSURANCE COMPANY: _____

NAME OF POLICY HOLDER (If different from above): _____

POLICY HOLDER DATE OF BIRTH_____

Insurance Policies and Fee Schedule

Consultation: includes practice member history. This service is complimentary.
Assessment (new or established practice member): includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $50-$100.
Chiropractic Adjustment: The actual re-alignment of the vertebra, done by an instrument or hand. Sometimes a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
Chiropractic Postural X-rays: Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $50 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Phil Falardeau, DC or Mary Falardeau, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____
Signature **Date**

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of reducing or correcting the subluxations or structural dysfunctions of joints and muscles that are associated with neurological alterations. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supportive, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____

Name (Printed)

_____ _____

Signature **Date**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT NAME HERE

_____ _____

SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

I AUTHORIZE DR. PHIL FALARDEAU AND/OR DR. MARY FALARDEAU AND ANY AND ALL LIVE FREE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY LIVE FREE CHIROPRACTIC.

_____ _____

DATE **GUARDIAN SIGNATURE**

_____ _____

WITNESS SIGNATURE & DATE **GUARDIAN'S RELATIONSHIP TO MINOR/CHILD**

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.
DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF LIVE FREE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, IT WILL BE BROUGHT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT YOUR NAME HERE DATE

_____ _____
SIGNATURE YOUR AGE

***FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT *LIVE FREE CHIROPRACTIC*.

_____ _____
SIGNATURE DATE

DO NOT WRITE BELOW THIS LINE **DO NOT WRITE BELOW THIS LINE** **DO NOT WRITE BELOW THIS LINE**

	AP	Lateral
Cervical		
Thoracic		
Lumbar		