

## Welcome to Miller Chiropractic

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

Were you aware that

- ...Doctors of Chiropractic work with the nervous system?  
 Yes       No
- ...the nervous system controls all bodily functions and systems?  
 Yes       No
- ...Chiropractic is the largest natural healing profession in the world?  
 Yes       No
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life?  
 Yes       No





## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Any amount authorized to be paid directly to this office will be credited to my account on receipt. It is understood and agreed the amount paid to the Doctor for x-rays is for examination only and the negative will remain the property of this office, being on file where they may be viewed.

I, \_\_\_\_\_ have read and fully understand the above statements.  
Practice Member Name (Please Print)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

### Acknowledgement of Receipt of Notice of Privacy Practices...

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Practice Member Signature)

\_\_\_\_\_  
(date)

# Present Health History

Name \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

## Part One: Function

Doctors of Chiropractic are interested and concerned with function – health. Vertebral Subluxations (nerve interference) can result in changing function. *Please take a moment and record your current level of function.*  
Directions: On the line below, please indicate your **current overall health** by placing a mark on the line which best describes your present **whole body health** – this includes head, trunk, extremities, organs and systems.

### Current Function/Health

Lowest \_\_\_\_\_ Highest  
0% \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 100%  
Function/Health 25% 50% 75% Function/Health  
Comments \_\_\_\_\_

## Part Two: Malfunction

*Note: If you feel that your body is working at its normal level of performance, then check the box here  and STOP!*

However, if there is a level of malfunction present, please indicate how your body is not working right – this does not necessarily mean pain, rather, a lowering or change in your health and performance – (it's just not working right). Example: digestive complaints, leg, arm, head, neck, back, heart, lung, etc. If more than one complaint is being experienced, please list numerically and define them as:

	(Constant: 75% - 100%)	(Intermittent: 30% - 74%)	(Occasional: 1% - 29%)
Parts Malfunctioning	Constant	Intermittent	Occasional
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Part Three: Activities of Daily Living

Please list how this has affected your life style and/or activities – example: cannot do sports, yard work, changes in work, relationships, etc. \_\_\_\_\_

Please place a mark on the line below which bests indicates your current activity level.

### Current Activity Level

Can not do \_\_\_\_\_ Can do  
0% \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 100%  
any activity 25% 50% 75% all activity

**Please turn over and complete**

**Part Four:**

**Pain**

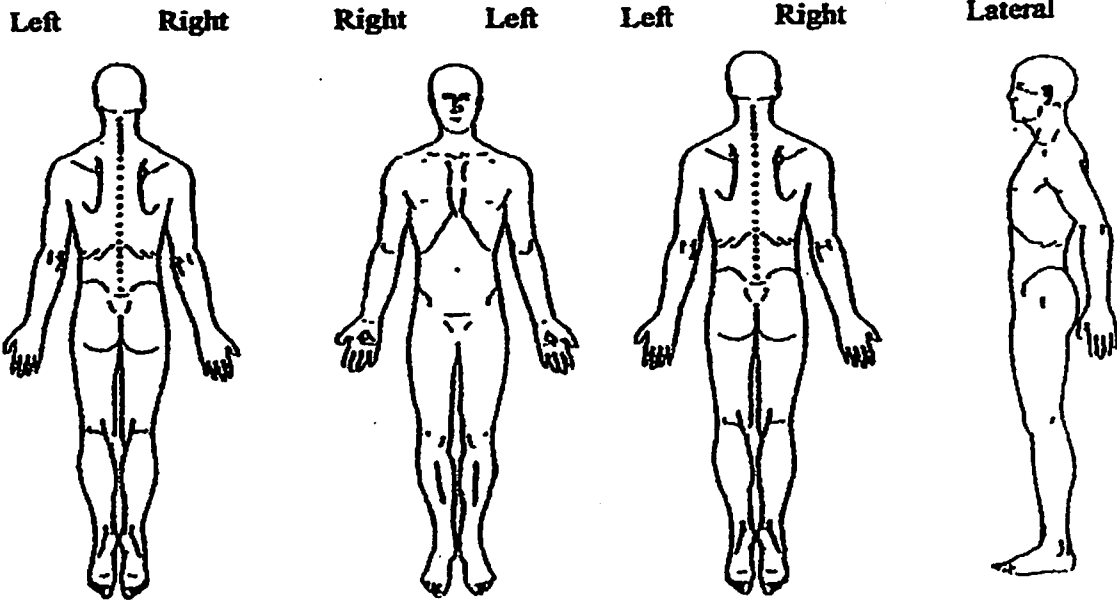
If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness (spasm), abnormal sensation), please shade in the area on the diagram below and label accordingly.

SP = Sharp Pain  
N = Numbness

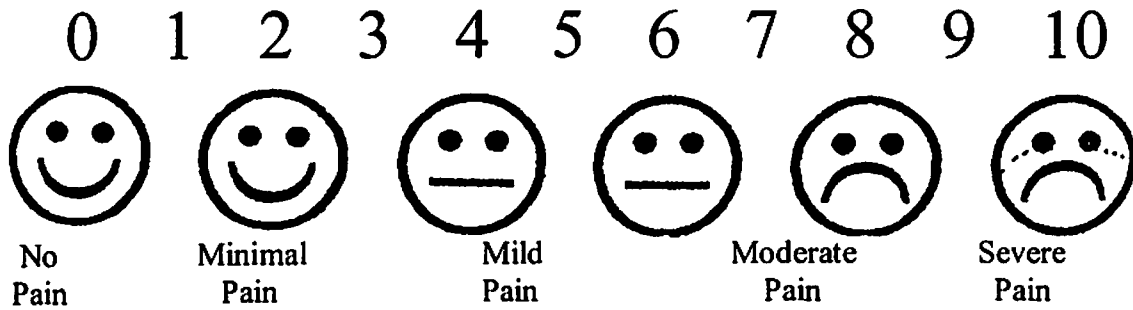
DP = Dull Pain  
T = Tingling

B = Burning  
ST = Stiffness (spasm)

S = Stinging  
A = Abnormal Sensation



**Pain Scale:** Please circle the number below (↓) that best describes your current pain and draw a line (or number that region) to the diagram above (↑).



**Part Five:**

**Referral Inquiry**

*(Please check one of the following)*

- I have referred family or friends to chiropractic care.
- I have referred family or friends to this office.
- I would gladly refer my family or friends to this office for care.
- I would not refer my family or friends to this office for care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date