Life Purpose Chiropractic Health History

Today's Date_____

PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____

Both Parent's names (if you are under 18)_____

Home Address _____ City _____ State _____ Zip _____
Phone _____

E-mail address_____

Occupation _____ Employer _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Dr. Rick Brescia can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work: Y N Driving: Y N Sleep: Y N Exercise/sports: Y N

School: Y N Walking: Y N Sitting: Y N Eating: Y N Love life: Y N

HEALTH CARE HISTORY

Have you ever received Chiropractic care? Yes No

How long under care? _____days _____weeks _____months _____ years

Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (circle all that apply)

Medical Physician Naturopath Acupuncturist Homeopath

Massage Therapist Psychotherapist Energy Healer Dentist

Reason: _____

_____

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

The primary system in the body which controls health and healing is the **NERVE SYSTEM**. The vertebrae (spinal bones) surround and protect the delicate **NERVE SYSTEM**. Injury to the **SPINE** and **NERVE SYSTEM** result in loss of communication between the brain and your body. This breakdown in communication is known as **VERTEBRAL SUBLUXATION**. Vertebral Subluxations are a result of not being able to deal with the stresses of daily life. When Subluxations are left uncorrected long enough, your body will start to breakdown and eventually develop symptoms. This can occur years after the origin of the Subluxation.

The information below will help us to see the types of stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether you may have uncorrected Subluxations not allowing your body to function at its full potential.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CIRCLE where and how you were birthed. (If you do not know, please skip to next question)

Home Natural Hospital Caesarian section Forceps

Breech Cord around neck Prolonged labor Drug induced labor Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present day.

Have you had any accidents due to any of the following? (Circle all that apply)

Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, state type of injury and date:

_____

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? Yes No

If yes, list body parts injured and dates of injuries:

Have you ever been hospitalized or had surgery? Yes No

If yes, state reason and dates:

_____

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma: Y N Loss of loved one: Y N Abuse: Y N

Work or School: Y N Divorce/separation: Y N Financial: Y N

Lifestyle change: Y N Parents' divorce: Y N Illness: Y N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

Toxic chemicals Chemotherapy Radiation Drug therapy Second hand smoke

Other _____

If yes, please list:_____

Do you have allergies or sensitivities to any foods? Y N

If yes, please list: _____

Please list all medications you are taking (prescribed and over the counter):_____

_____

_____

QUALITY OF LIFE (presently)

How do you grade your physical health? Good Fair Poor

How do you grade your emotional/mental health? Good Fair Poor

How do you rate your overall "quality of life"? Good Fair Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

We believe that everyone should be able to do the things they love to do when they want to do them. In order for you to have the best life possible, you need to have an optimal functioning nervous system. We want everyone to have optimal health, but not everyone chooses this for themselves.

YOUR EXPECTATIONS FROM YOUR CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Circle all that apply)

Relief and Prevention of a problem

Healthier spine and nerve system

Optimal health on all levels

OTHER_____

PLEASE READ AND SIGN

I understand that most care is given in a semi- open setting. A private appointment can be made available upon request.

I consent to receive communication from Dr. Rick Brescia via email, postal mail, text and telephone messaging in connection with my care.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

I give Dr. Rick Brescia permission to render care to me. I understand that all my health information will be kept confidential and can only be released with my written permission.

Name: (Printed) _____Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Dr. Rick Brescia as your Gonstead Family Chiropractor. We look forward to serving you. YOUR LIFE AND HEALTH ARE OUR PURPOSE!

Practice Member Health Information Consent Form

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

We want you to know how your Practice Member Health Information (PMHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Practice Member Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The practice member understands and agrees to allow this Chiropractic office to use their Practice Member Health Information for the purpose of care, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PMHI to the Health Insurance Company (or companies) provided to us by the practice member for the purpose of payment. Be assured that this office will limit the release of all PMHI to the minimum needed for what the insurance companies require for payment.
2. The practice member has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PMHI. Our office is not obligated to agree to those restrictions.
3. A practice member's written consent need only be obtained one time for all subsequent care given to the practice member in this office.
4. The practice member may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given after the request has been presented.
5. For the security and right to privacy, all staff has been trained in the area of practice member record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Practice members have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the practice member refuses to sign this consent for the purpose of care, payment and healthcare operations, the chiropractor has the right to refuse to give care.

I have read and understand how my Practice Member Health Information will be used and I agree to these policies and procedures.

Name of Practice Member Date

Life Purpose Chiropractic LLC Office Policies

- Health and healing is a team effort, therefore, staying on track with you care is extremely important.

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

- Because health builds momentum and your body heals in rhythm, one of the **most important** aspects about your chiropractic care is to **stay on schedule!** If a practice member will be missing a scheduled appointment, they must provide notice **24 hours** in advance. If you fail to notify us within 24 hours you will be subject to a $25.00 inconvenience charge.
- All missed and rescheduled appointments **must be made up within 3 office days**.
- This office has a 3 strike rule, which means if any practice member misses more than 3 visits **without** making up those visits; their care will be suspended until they attend another Optimal Health workshop. If they fail to comply, they will be dismissed as practice members and money for services not yet rendered will be refunded.
- Adjusting times are for **Adjustments ONLY.** If you have a concern that needs to be addressed. Please set up a personal meeting with the doctor for another time and he will gladly address whatever issue is at hand.
- Your care schedule is determined based upon clinical evidence evaluated by Dr. Rick. If for some reason, **YOU** feel you need additional care that is **NOT** recommended by Dr. Rick, you will be charged the full fee of that visit which is $50.00/ visit.
- Discounts only apply to care plans, not visits. If for some reason, the practice member decides to terminate care for any reason, your care will be prorated and any balance will need to be taken care of immediately. If a refund is needed, it will be provided to you.
- Our team is totally committed to the health of the children in this community. Likewise, we are dedicated to the early detection of spinal and nervous system problems **before** they become symptomatic. We want the best for our children and the children of our practice members, we recommend your kids have a Chiropractic check up **as well.** This can be scheduled within the first two weeks of you starting care for a discount.
- Our team members are dedicated to providing the highest quality service possible to you and your family. If as an informed parent, you decide to deny your child(ren) the right to care, and you bring them to the office with you, they must accompany you during your adjustment. This allows the team to provide equal service to the needs of all practice members.
- Life Purpose Chiropractic is a family-oriented health facility. Therefore, smoking is not allowed on or near the premises. If you absolutely MUST smoke, you may do so in the confines of your vehicle ONLY. This applies to any and all guest you bring to the office as well.
- If female, we can provide you with a gown during your adjustments if you feel you need it.

I agree to the aforementioned statements.

_____ _____

Signature Date

_____ _____

Provider Date

Life Purpose Chiropractic LLC Terms of Acceptance

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

Chiropractic has only one goal. It is important that each practice member understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Here are some definitions that the practice member must understand:

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092

1. **ADJUSTMENT**: The 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.

2. HEALTH: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

3. 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.

4. INNATE INTELLIGENCE: The body's inborn ability to heal, maintain, and organize itself at an maximum health potential.

We do not offer diagnosis or treatment of any disease. We only offer to diagnose vertebral subluxation. However, during the course of a Chiropractic spinal examination 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 another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

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

Therefore, I accept Chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive ChiropracTIC care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____

_____ _____
(Signature) (Date)

16626 W. 159th St. #700 Lockport, IL. 60441 dr.rickbrescia@gmail.com 773-842-9092