Chiropractic Connection
Dr. Dana Tankell

ADULT WELLNESS
PROFILE

File: _____

Practice Member Information

Name: _____

Appointment Date M _____D _____20 _____ Birth Date M _____ D_____ Y _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May we leave a message? ☐Yes ☐No

Cell Phone: _____ May we leave a message? ☐Yes ☐No

Work Phone: _____ May we leave a message? ☐Yes ☐No

Email: _____

May we add you to our email newsletter and calendar of events? *(Your email will not be shared)* ☐Yes ☐No

Spouse's name? _____

Name(s) and age(s) of children: _____

Occupation: _____ Do you primarily: ☐Sit ☐Stand ☐Perform repetitive tasks

How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐Yes ☐No

Who was your previous Chiropractor? _____

Where? _____ When? _____

Were X-rays taken in the last 6 months? ☐Yes ☐No

What was the primary reason for consulting that office?

☐Relief Care - Symptom relief of pain or discomfort

☐Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

☐Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? ☐Yes ☐No

Please explain: _____

Are you wearing: ☐Heel Lifts ☐Custom Orthotics

Family Doctor: _____

Date and reason of last visit: _____

May we contact your family doctor regarding your care at our office if necessary? ☐Yes ☐No

Naturopathic Doctor: _____

Date and reason of last visit: _____

Other Specialists and healthcare professionals:

Name: _____ Professional Designation: _____

Date and reason of last visit: _____

Name: _____ Professional Designation: _____

Date and reason of last visit: _____

Wellness Profile

Do you have a specific concern that brings you in?

☐No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.

☐Yes: ***If yes, please answer the following questions:***

What is your primary area of complaint today? _____

How long have you been aware of this? ☐days ☐weeks ☐months ☐years

Where else does this pain go in your body? _____

How often do you experience this? ☐daily ☐weekly ☐monthly ☐comes and goes ☐constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? _____

How would you describe the pain/discomfort?

☐Dull ☐Achy ☐Throbbing ☐Stabbing ☐Tight/Stiff ☐Burning ☐Sharp ☐ Other: _____

What makes it feel worse? _____

What makes it feel better? _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? ☐Yes ☐No

Do you feel your condition can be healed? ☐Yes ☐No

What have you tried that ***has*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic ☐Other: _____

What have you tried that ***hasn't*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic ☐Other: _____

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (***Page5***)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height: _____ Weight: _____

Are you happy with your current physical appearance and abilities? ☐Yes ☐No

Frequency of exercise/week: Cardio? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Weight bearing? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Do you stretch after exercise or after other activities of poor posture? ☐Yes ☐No ☐Sometimes

No Hours of sleep/night? ☐>6 ☐7-9 ☐10

Do you feel refreshed upon waking? ☐Always ☐Sometimes ☐Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐Yes ☐No

Which position do you sleep? ☐Back ☐Belly Side ☐Right ☐Left ☐Both

Number of hours spent commuting/week? ☐0-2 ☐3-5 ☐6-8 ☐9-11 ☐12+

Number of hours spent at a desk or computer/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Number of hours spent on smart device/tablet/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Do you perform any repetitive tasks at home or at work? ☐Yes ☐No

Have you ever been hospitalized or had surgery? ☐Yes ☐No

If yes why and when? _____

Have you ever been in a motor vehicle accident (even if it was minor)? ☐Yes ☐No

If yes, what kind and when? _____

Were you evaluated and treated after each accident? ☐Yes ☐No

Have you had any non-vehicle accidents or falls? ☐Yes ☐No

Early Years

To your knowledge, was your delivery difficult? ☐Yes ☐No

If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐ Other: _____

Were you breast fed? ☐No ☐Yes For how long? _____ Did you experience emotional trauma as a child? ☐Yes ☐No

Were you ever given antibiotics as a child? ☐Yes ☐No Did you ever have ear infections as a child? ☐Yes ☐No

Any major childhood illness? ☐Yes ☐No

Emotional

Rate your current level of personal stress in your life: ☐None ☐Low ☐Moderate ☐High

Rate your current level of relationship stress in your life: ☐None ☐Low ☐Moderate ☐High

Rate your current level of financial stress in your life: ☐None ☐Low ☐Moderate ☐High

Rate your current level of health stress in your life: ☐None ☐Low ☐Moderate ☐High

Rate your current level of family stress in your life: ☐None ☐Low ☐Moderate ☐High

Rate your current level of career stress in your life: ☐None ☐Low ☐Moderate ☐High

Do you feel you have a supportive network of friends and family? ☐Yes ☐No

Do you feel you have healthy coping strategies for life stress? ☐Yes ☐No

Chemical

Were you vaccinated as a child? ☐Yes ☐No

Any adverse reactions to vaccines? ☐Yes ☐No

Do you choose to have annual flu shots? ☐Yes ☐No

Do you take antibiotics? ☐Yes ☐No, How often? _____

How many glasses of water/day: ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+

How many glasses of caffeinated beverages/day: ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+

How many glasses of cow's milk, juice and pop/day: ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+

Do you eat gluten? ☐Yes ☐No ☐Trying to eliminate from diet

Do you eat dairy? . ☐Yes ☐No ☐Trying to eliminate from diet

Do you eat refined sugars? (white sugar, white bread and pasta) ☐Yes ☐No ☐Trying to eliminate from diet

Do you eat boxed/frozen foods? ☐Yes ☐No ☐Trying to eliminate from diet

Do you choose organic foods? ☐Yes ☐No, which: ☐Veggies ☐Fruits ☐ Meats ☐Grains

All Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . ☐Yes ☐No

Any food/drink allergies, sensitivities, intolerances? ☐Yes ☐No

Do you smoke? ☐Yes ☐No ☐I used to for ____ years ☐I wish I didn't

Are you or have you been exposed to secondhand smoke? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No ☐0-6/week ☐6-12/week ☐12+/week

Do you take a probiotic daily? ☐Yes ☐No _____ CFU's/day

Do you take vitamin D3 daily? ☐Yes ☐No _____ IU's/day

Do you take Omega 3 Fish Oils daily? ☐Yes ☐No _____ mg/day Capsule Liquid

Other supplements or homeopathics? _____

Any other daily medication and their purpose? _____

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐Yes ☐No

Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

☐Relief Care - Symptom relief of pain or discomfort
☐Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
☐Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system

Do you have other concerns we should know about?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Goals & Consent

What is your primary goal for consulting our clinic?

_____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

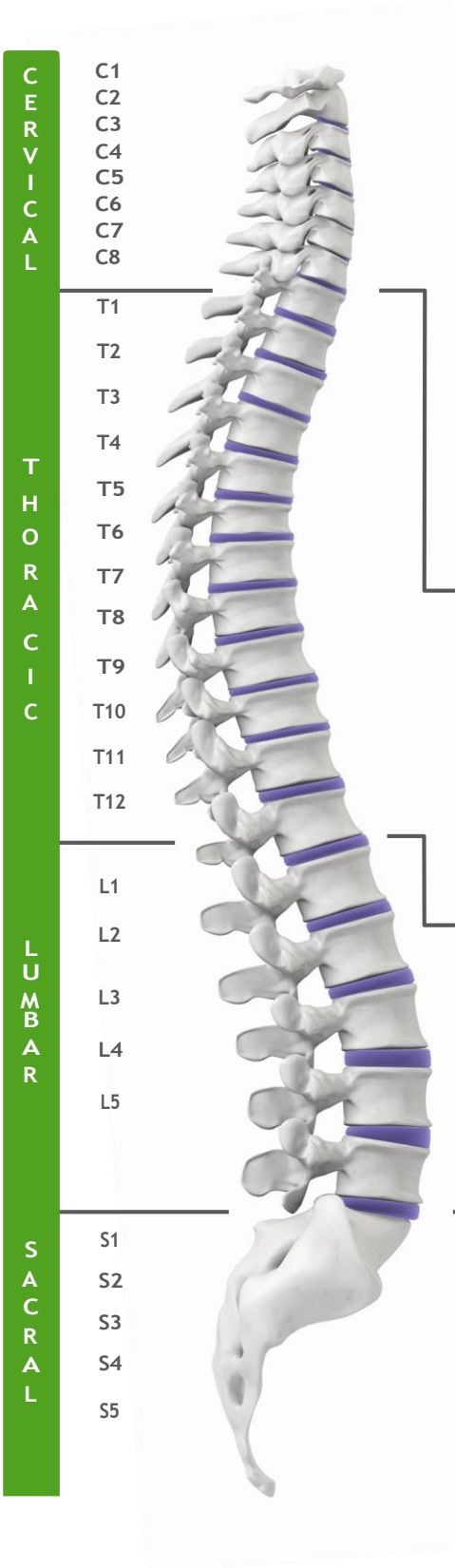
Consent to Evaluation

I _____hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

SPINAL NERVE



ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

C1 C2 C3 C4 C5 C6 C7 C8

Parotid Gland • Scalp
Base of Skull • Eyes
Lacrimal Gland • Sinuses
Inner, Middle & Outer Ear
Nose • Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles • Diaphragm
Shoulders • Elbows • Arms
Wrists • Hands & Fingers
Tonsils • Vocal Cords
Esophagus • Heart
Lungs • Chest • Thyroid

T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

Arms • Wrists
Esophagus • Chest • Heart
Lungs • Trachea • Larynx
Diaphragm • Stomach
Gallbladder • Liver
Pancreas • Small Intestine
Spleen • Kidneys • Appendix
Adrenals • Colon • Buttocks
Uterus • Ovaries • Testes

L1 L2 L3 L4 L5

Large Intestine • Colon
Thighs • Buttocks • Groin
Knees • Legs • Feet
Reproductive Organs

S1 S2 S3 S4 S5

Buttocks • Groin • Legs
Ankles • Feet • Toes
Prostate Gland • Bladder
Reproductive Organs

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

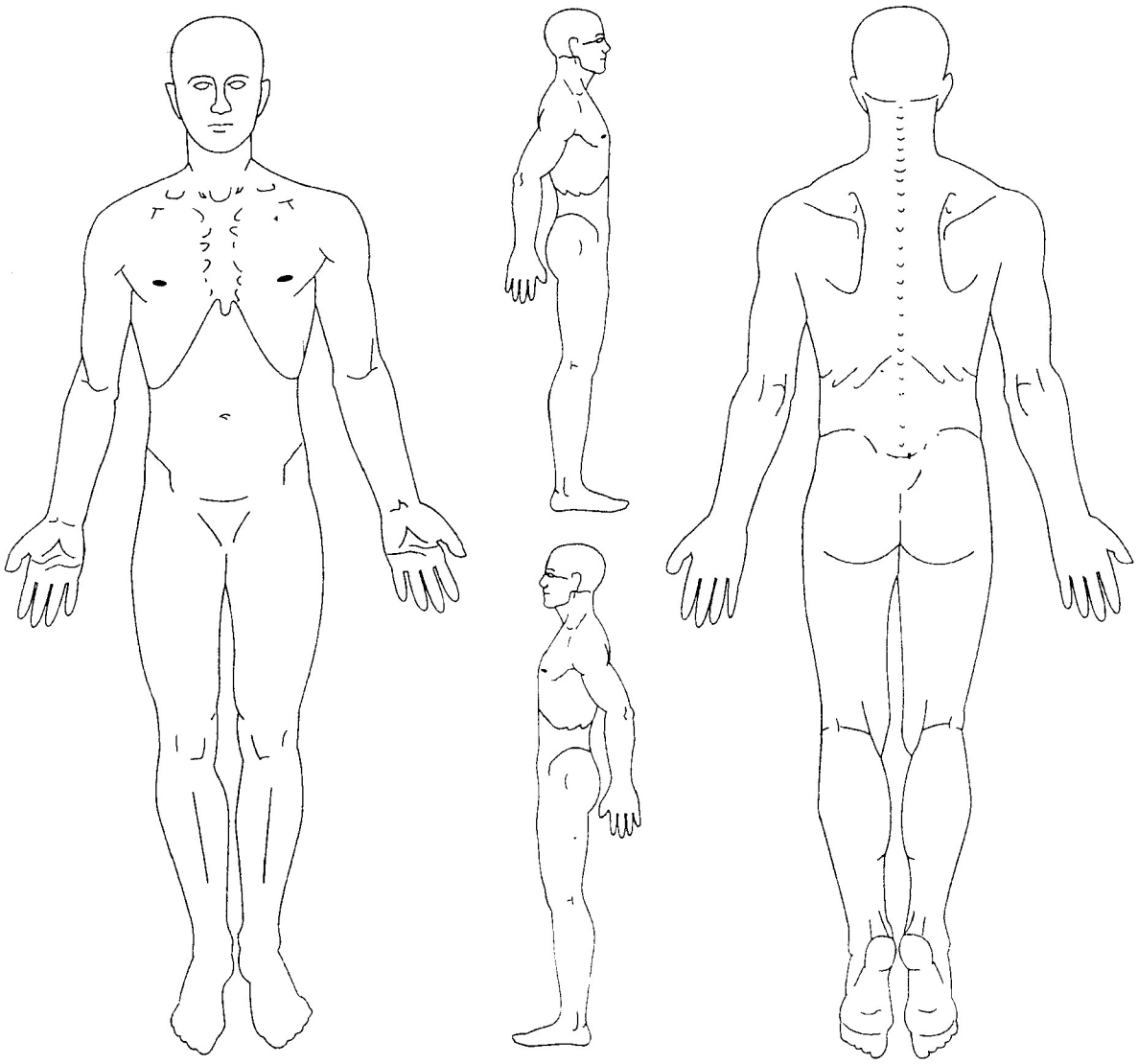
CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Sinus & Ear Pain/Infection	☐	☐	Anxiety & Stress
☐	☐	Runny Nose & Allergies	☐	☐	Seizures
☐	☐	Frequent Head Colds	☐	☐	ADD/ADHD
☐	☐	Sore Throat & Tonsilitis	☐	☐	Thyroid Dysfunction
☐	☐	Strep Throat	☐	☐	Metabolic Dysfunction
☐	☐	Chronic Cough & Croup	☐	☐	Insomnia
☐	☐	Difficulty Breathing	☐	☐	High/Low Blood Pressure
☐	☐	Poor Immunity	☐	☐	Enlarged Lymph Glands
☐	☐	Dizziness & Vertigo	☐	☐	Migraines & Headache
☐	☐	Tinnitus & Ear Fullness	☐	☐	TMJ Pain
☐	☐	Vision Problems	☐	☐	Stiff Neck
☐	☐	Watery/Dry Eyes	☐	☐	Arm Pain
☐	☐	Chronic Fatigue	☐	☐	Hand/Finger Numbness
☐	☐	Poor Concentration	☐	☐	Loss of Grip Strength
☐	☐	Depression			
☐	☐	Asthma	☐	☐	Kidney Stones
☐	☐	Bronchitis & Pneumonia	☐	☐	Gall Bladder Attacks
☐	☐	Congestion	☐	☐	Skin Conditions & Rashes
☐	☐	Reflux & GERD	☐	☐	Menstrual Cramps/PMS
☐	☐	Indigestion & Heartburn	☐	☐	Infertility
☐	☐	Stomach Pains	☐	☐	Menstrual Dysfunction
☐	☐	Ulcers	☐	☐	Rashes & Eczema
☐	☐	Gas & Bloating	☐	☐	Hyperactivity
☐	☐	Jaundice	☐	☐	Shoulder Pain
☐	☐	Liver Conditions	☐	☐	Midback Pain
☐	☐	Blood Sugar Dysregulation	☐	☐	Rib Pain
☐	☐	Irritable Bowel, Colitis, Crohn's	☐	☐	Prostate Dysfunction & Impotence
☐	☐	Gas Pain & Constipation	☐	☐	Ovarian Cysts & Endometriosis
☐	☐	Diarrhea	☐	☐	Fertility Problems/ Loss of Menstruation
☐	☐	Hemorrhoids	☐	☐	Low Back Pain
☐	☐	Bladder Infections Bladder	☐	☐	Hip Pain
☐	☐	Incontinence & Bedwetting	☐	☐	Thigh Pain
☐	☐	Painful/Excessive Urination	☐	☐	Numbness & Tingles in Legs
☐	☐	Varicose Veins	☐	☐	Sciatica
☐	☐	Leg Cramping	☐	☐	Pelvic Pain
☐	☐	Restless Legs	☐	☐	Knee Pain
☐	☐	Poor Circulation & Cold Feet	☐	☐	Ankle Pain & Sprains
			☐	☐	Foot Pain & Weak Arches

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

o Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

o Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

EXPLANATION OF PROFESSIONAL FEES

CONSULTATION: No charge
The consultation takes place subsequent to the new patient history examination. The doctor will discuss with the patient any current complaints. The doctor will also give the patient a brief explanation of the
chiropractic and the care they will be receiving.

CHIROPRACTIC EXAMINATIONS: $50-225
New patient history examination:
A case history on the new patient involves questions regarding the past and present health complaints. The doctor also performs various ranges of motion, orthopedic, neurological, and/or chiropractic tests.

BRIEF EXAMINATION: $40-80
Consists of the doctor questioning the patient as to their subjective status prone and supine leg length differential tests, Derryfield, spinal motion palpation and cervical syndrome tests to determine the patient status objectively. Based on the above, the doctor determines whether the patient requires a corrective adjustment on that visit.

ESTABLISHED PATIENT RE-EXAMS: $60
Subsequent to the 12th-15th visit the doctor will perform several chiropractic tests so that she may further evaluate the patient's progress.

CHIROPRACTIC X-RAY STUDIES: $75-175
Subsequent to the consultation, and after careful review of the patient's complaint, the doctor will determine if x-rays are necessary for the proper care of the patient.

CHIROPRACTIC ADJUSTMENT: $40-95
The chiropractic adjustment is the correction parentheses reduction parentheses of a subluxated vertebrae or pelvic segment by means of making a specific, predetermined adjustment. The chiropractic adjustment is made only after careful analysis, delivered in a specific manner, to achieve a predetermined goal. It is a precise, delicate maneuver, requiring special bioengineering skills and deftness.

SIGNATURE _____ DATE _____

CHIROPRACTIC CONNECTION
FINANCIAL AGREEMENT

We would like to take a moment to welcome you to _____ and to assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled. Charges for treatment in this office are due and payable at the time the service is performed. However, if this in inconvenient for you, we will be glad to set up a payment plan to assist you while your are under current care in our office.

PAYMENT PLAN

_____ CASH: I agree to pay the entire balance owing on a daily/weekly basis. I agree to pay any outstanding balance with one month after termination of my care. I further agree to pay a late payment fee of $_____for any balance that is over 30 days past due.

_____ INSURANCE: I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and $_____ / _____% of my co-payment portion per visit/week/month.

_____ PERSONAL INJURY: I agree to allow _____to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no coverage is available or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred on a daily/weekly/monthly basis.

_____ 3rd PARTY CLAIM: I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree to be personally responsible to pay charges incurred on a daily/weekly/monthly basis (or at the time of settlement of my claim).

_____ ATTORNEY LIEN: I understand that _____has agreed to defer the balance of any unpaid charges until settlement of my claim/lawsuit. I further understand that if I change attorneys or release my attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

_____ MEDICARE: I understand that my Medicare insurance policy covers 80% manipulation treatment only. I agree to be personally responsible for all charges which are not covered by Medicare, including my $100 yearly deductible, and the 20% co-payment amount for covered services, at the time those services are rendered.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I have read and agree to the above:

_____ _____

Patient's Signature Date

CHIROPRACTIC CONNECTION
DR. DANA TANKELL

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 used 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 vertebrae in the spinal column which causes alteration of nerve function and interface 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 examination, we encounter non-chiropractic or unusual finding, 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 a 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 statement.

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

I therefore 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 period:_____.

Signature and Date_____

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CARFULLY.

As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment & Payment Purposes
We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or a medical billing clearinghouse or collection agencies for the purpose of payment of your health care services. This office utilizes an outside billing service.

Workers' Compensation
We may disclose your health information as necessary to comply with state Work Comp Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Other
As required by law, we may disclose your health information to the following persons or entities:

- Public Health Authorities
- Law Enforcement Officials
- Medical Examiners or Coroners
- Approved Medical Research or Review Board
- Public Safety Officers
- Specialized Government Agencies

Communications
We may contact you for additional communications, or other purposes, as described below:

It is our policy to call your home on the day prior to your scheduled appointment to remind you or your appointment time. A reminder message is left with a person or answering machine if you are not at home.

Birthday cards and/or seasonal greeting cards are sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift or medical reminders. These greeting cards are often post cards and are not enclosed in a sealed envelope. In the office, you maybe asked to sign in and your name may be called out loud. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy.

Change of Ownership
In the event that this practice is sold or merged with another organization, your health record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by our office.
- You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office manager.

Complaints

Complaints about your Privacy Rights, or how our office handles the use or disclosure of your health information should be directed to our office manager.

If your are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

_____ _____ _____

Patient's Name (print) Signature Date