Dr. Loren Stockton, CCN, DACBN
Health for Living Chiropractic, PC

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WELCOME, NEW PATIENT!

1. All new patients are requested to fill out new patient paperwork as well as health history forms.
2. The first appointment will be a consultation with the doctor to discuss your healthcare.
3. A diagnostic chiropractic, orthopedic and neurological examination will be performed to determine if chiropractic care is appropriate for you. The doctor will advise you if there is a need for any additional procedures, such as laboratory work or x-rays.
4. The doctor will inform you when to return for the following visit in a "Report of Findings." The second visit will include the doctor's recommended treatment plan.
5. The front desk will inform you of your insurance coverage and what you should be financially responsible for at each visit. Please bring your insurance card with you to the first visit.

PERSONAL HISTORY

Name: ______________________________ **Date:** ______________

Address: ____

City: ______________________ **State:** _______ **Zip Code:** ____________

Home #: ______________ **Work #:** ______________ **Cell #:** ______________

Email Address: ______________________________ **Sex:** ( )M ( )F

Birth Date: ______________ **Age:** _______ **SSN#:** ______________

Employer: ____

Type of Work: ____

Check One: ( )Single ( )Married ( )Divorced ( )Separated ( )Widowed ( )Life Partner

Emergency Contact: ______________________ **Phone #:** ______________

Spouse's Name: ______________________ **Work #:** ______________

Number of Children: ______________ **Referred By*:** ______________

*Please initial here indicating your permission to thank the person(s) that referred you. ____________

CURRENT HEALTH CONDITION

'urrent health problems:

1. ______
2. ______
3. ______
4. ______
5. ______

Other Doctors seen for this condition: ______

When did each condition begin?: 1.______ 2.______ 3.______ 4.______ 5.______

What do you think is wrong?: ______

If disabled from work, please give dates: ______

☐ Job related ☐ Auto related

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Broken Bones ☐ Hysterectomy

☐ Other: ______

☐ Accidents or Falls: ______

☐ Fender Benders: ______

☐ Have you ever been knocked unconscious? ______

Hospitalization (Other than above): ______

Have you been x-rayed in the last year? ☐ Yes ☐ No

Date and Place: ______ ☐ Spine ☐ Extremity ☐ Chest

Explain any extreme mental, chemical (toxic) or physical stress you have been exposed to in the past or present:

______

Previous Chiropractic Care: ☐ None

☐ Doctor's name and approximate date of last visit: ______

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain: ______

FAMILY HISTORY

Past and Present Health Problems

Mother (Age) ______

Father (Age) ______

Brothers ______

Sisters ______

Any familial or congential health problems?: ______

C
CCMI

ADDITIONAL COMPLAINT QUESTIONNAIRE

NAME ____________________

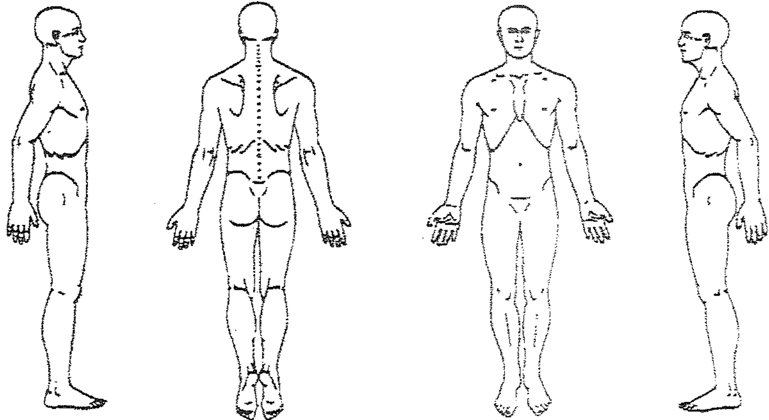
In the space below, please describe any additional or other complaint which brought you to this clinic for care.

1. Please Describe Your Complaint: ____________________

a. Description:
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency:
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25%or less)

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Intensity: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

d. Have your symptoms ☐ decreased ☐ not changed ☐ increased?

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day.

2. a. How long has your problem been present? _____ days _____ weeks _____ months _____ years.
   b. If it followed a specific incident please date & describe: ____________________
   c. If from lifting, how many lbs? _______ In what position were you? ☐ Bent forward ☐ Bent backwards ☐ Knees bent ☐ Twisted
   Did you lift ☐ once ☐ a few times ☐ many times ? Do you repeat the same motion often? ☐ Yes ☐ No

3. What doctors/providers *have* you seen *for this episode*? ☐ DC ☐ MD ☐ DO ☐ PT *Currently are* seeing? ☐ DC ☐ MD ☐ DO ☐ PT
   a. Examinations included: ☐ X-Rays ________ (DATE) ☐ MRI ________ (DATE) ☐ CT ________ (DATE) ☐ Other ____________
   Comments: ____________________
   b. Treatment has included: ☐ Exercise ☐ Heat ☐ Cold ☐ Medications ☐ Support ☐ Electrical Therapy ☐ Manipulation ☐ Surgery
   Comments: ____________________

4. *In the past* have you been treated for the same or a similar problem? ☐ Yes ☐ No If yes, when? __________
   Type of provider seen? ☐ DC ☐ MD ☐ DO ☐ PT ____________

5. What makes your problem better? ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

7. Does your complaint affect your ability to work or otherwise be active? (Check any that apply.)
   a. ☐ No effect.
   b. ☐ Able to perform everyday tasks, but with pain.
   c. ☐ Need assistance often.
   d. ☐ Unable to function without assistance.
   e. ☐ Cannot perform usual work duties as of ____________(date).
   f. ☐ Cannot work at all as of ____________(date).

Patient's Signature: ____________________ Date: ___/___/___

FOR DOCTOR'S USE ONLY FOR DOCTOR'S USE ONLY FOR DOCTOR'S USE ONLY

Present Complaint: ____________________

Date of onset: ________ Mechanism of Onset/ADL: ____________________ ☐ Back Index ☐ Neck Index

Prior Treatment and Response for this complaint: ____________________

Pre-Existing Status of Problem Area: ____________________

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If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it i the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

PATIENT HEALTH QUESTIONNAIRE

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)

Past	Present	
☐	☐	Depression (311)
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Anorexia (307.1)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9) / Gallbladder (575.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Other________

If a family member has had any of the following please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other Conditions ________
☐ High Blood Pressure	________

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location ________
☐	☐	Date rating received ____/____/____
		Rating Percentage ________%

Present: Weight ______ pounds **Height** ___ feet _____ inches

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Medications (list if not listed elsewhere) ________ ________
☐	☐	Hospitalization/Surgical Procedures (list if not described elsewhere) ________ ________

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day________

Patient's signature: ________________ **Date:** ____/____/____

Doctor's Additional Comments/General Health Concerns:

____

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DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________ Date: __________

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month ☐ Past week ☐ Past 48 hours

Point Scale: 0—*Never or almost never* have the symptom 1—*Occasionally* have it, effect is *not severe* 2—*Occasionally* have it, effect is *severe* 3—*Frequently* have it, effect is *not severe* 4—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia TOTAL ______

EYES
- ______ Watery or itchy eyes
- ______ Swollen, reddened or sticky eyelids
- ______ Bags or dark circles under eyes
- ______ Blurred or tunnel vision TOTAL ______

EARS
- ______ Itchy ears
- ______ Earaches, ear infections
- ______ Drainage from ear
- ______ Ringing in ears, hearing loss TOTAL ______

NOSE
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attacks
- ______ Excessive mucus formation TOTAL ______

MOUTH/ THROAT
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Swollen or discolored tongue, gums, lips
- ______ Canker sores TOTAL ______

SKIN
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Flushing, hot flashes
- ______ Excessive sweating TOTAL ______

HEART
- ______ Chest pain
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat TOTAL ______

LUNGS
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing TOTAL ______

DIGESTIVE TRACT
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Constipation
- ______ Bloated feeling
- ______ Belching, passing gas
- ______ Heartburn
- ______ Intestinal/stomach pain TOTAL ______

JOINTS/ MUSCLE
- ______ Pain or aches in joints
- ______ Arthritis
- ______ Stiffness or limitation of movement
- ______ Feeling of weakness or tiredness
- ______ Pain or aches in muscles TOTAL ______

WEIGHT
- ______ Binge eating/drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Water retention
- ______ Underweight
- ______ Compulsive eating TOTAL ______

ENERGY/ ACTIVITY
- ______ Fatigue, sluggishness
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness TOTAL ______

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Difficulty in making decisions
- ______ Stuttering or stammering
- ______ Slurred speech
- ______ Learning disabilities
- ______ Poor concentration
- ______ Poor physical coordination TOTAL ______

EMOTIONS
- ______ Mood swings
- ______ Anxiety, fear, nervousness
- ______ Anger, irritability, aggressiveness
- ______ Depression TOTAL ______

OTHER
- ______ Frequent illness
- ______ Frequent or urgent urination
- ______ Genital itch or discharge TOTAL ______

GRAND TOTAL TOTAL ______

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt.)
If yes, how many are you currently taking? _____ (1 pt. each)
☐ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
☐ Cimetidine (2 pts.)
☐ Acetaminophen (2 pts.)
☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt.) ☐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of
☐ Environmental and/or chemical sensitivities (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

GRAND TOTAL: __________

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE _________ (High >50; moderate 15-49: Low <14)
XTT SCORE _________ (High >10; moderate 5-9: Low <4)

MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support

Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

Approximately how many of the following foods do you consume each **week**?

1. Glasses of:
- Whole milk ______
- Skim milk ______
- Cream ______
- Buttermilk ______
- Soy milk ______

Servings of:
- Cheese ______
- What kind ______
- Yogurt ______

2. Servings of:
- Eggs ______
- Beef ______
- Pork ______
- Veal ______
- Liver ______
- Bacon ______
- Fowl ______
- Fish ______
- Shell fish ______
- Lunch meat ______
- Canned meat ______

3. Servings of:
- Cereals (hot) ______
- Cereals (cold) ______
- Sugar-coated ______
- Pancakes ______
- Waffles ______
- Crackers ______
- Rice (brown) ______
- Rice (white) ______
- Rice (wild) ______
- Macaroni ______
- Spaghetti ______
- Soup (canned) ______
- Soup (fresh) ______

4. Servings of:
- Pie ______
- Cake ______
- Jello/pudding ______
- Candy ______
- Candy bars ______
- Doughnuts ______
- Ice cream ______
- Chips ______

5. Glasses of:
- Juice ______
- What kind ______
- Soda/Pop ______
- Spring water ______
- Water (city) ______
- Water (well) ______

6. Servings of:
- Potatoes ______
- Carrots ______
- Beans (yellow) ______
- Beans (green) ______
- Beans (dried) ______
- Corn ______
- Squash ______
- Spinach ______
- Lettuce ______
- Celery ______
- Green peas ______
- Broccoli ______
- Cauliflower ______
- Asparagus ______
- Onions ______
- Tomatoes ______
- Green pepper ______
- Cabbage ______
- Turnips ______
- Beets ______
- Others ______

7. Servings of:
- Oranges ______
- Grapefruit ______
- Pineapple ______
- Melon ______
- Apples ______
- Pears ______
- Bananas ______
- Grapes ______
- Raisins ______
- Apricots ______
- Peaches ______
- Plums ______
- Strawberries ______
- Raspberries ______
- Blueberries ______
- Others ______

8. Servings of:
- Peanuts ______
- Peanut butter ______
- Other nuts ______
- Jellies ______
- Mayonnaise ______

9. What vegetable oil do you use in cooking? ______ in salads ______

10. Do you use any fats or compounds when cooking? ______ What kind? ______

How many per **day** do you consume of the following:

11. Pats of:
- Butter ________
- Margarine ________

12. Slices of:
- Wheat Bread ________
- White Bread ________
- Rye Bread ________
- Corn Bread ________
- Sweet Bread ________
- Others ________

13. Glasses of:
- Water ________
- Beer ________
- Wine ________
- Alcohol drink ________

14. Cups of:
- Coffee (regular) ________
- Coffee (decaf) ________
- Tea ________
- Herbal ________

15. Do you use Salt:
- Freely ________
- Moderately ________
- Sparingly ________
- Never ________

16. Do you use Vinegar:
- Freely ________
- Moderately ________
- Sparingly ________
- Never ________

17. About how many teaspoons of sugar do you add to your food/drinks each day?

____

18. Has this been your average diet for the past three years? ________________________

19. What, if any, foods disagree with you? ________________________

20. Do you have indigestion? ________________________

21. What did you eat for breakfast yesterday? ________________________

____

22. What did you eat for lunch yesterday? ________________________

____

23. What did you eat for supper yesterday? ________________________

____

24. What beverages did you have yesterday? ________________________

25. What food or beverages did you have between meals? ________________________

____

26. Are you fond of:

Meat	____yes ____no	Cereals	____yes ____ no	Sweets	____yes ____no
Fruits	____yes ____no	Vegetables	____yes ____no	Butter	____yes ____no
Fats	____yes ____no	Breads	____yes ____no		

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Informed Consent to Health Care Treatment

The nature of health care/chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as electrical muscle stimulation, electrical needle-less acupuncture, other non-needle acupuncture devices, needle acupuncture, manual muscle and soft tissue release techniques, and traction may be used as well. Nutritional and herbal supplements may also be used. The doctors of chiropractic in this office have received education and training in the use of Applied Kinesiology (AK) and Contact Relflex Analysis (CRA) to assist in evaluating your body's nervous system. AK was developed by George Goodheart, DC in 1964. While there has been some peer review research and publications about AK in professional journals, some of the techniques have not been supported by a body of evidence using standard scientific research and methods. This office will use AK testing, as well as laboratory testing procedures if needed.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. The estimates of this occurring are from one in one million to one in ten million, and can be further reduced with screening procedures. In other words, the probability is extremely rare. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, redness/minor bruises from needle insertions, or minor digestive/pain from a nutritional product. Some patients can react to food compounds as an allergy, or be sensitive to specific nutrient compounds.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make further rehabilitation more difficult.

Nutritional Informed Consent: A vitamin, mineral, amino acid, fatty acid, antioxidant, herb or homeopathic remedies may have an effect on any disease process or symptoms, and this does not mean that it can be misrepresented, or be classified as a drug by anyone. A drug is defined as "articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease" as tested by the Food, Drug, and Cosmetic Act. Therefore, please be advised that any suggested nutritional or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular body symptom. Nutritional counseling, recommendations, and the adjunctive schedule of nutrition is provided solely to upgrade the quality or foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical process of the human body.

Cancer Informed Consent: This is applicable to those patients with a diagnosis of cancer seeking health care advice from this office. It is understood by you that the doctors and this clinic are not held responsible for the reversal, cure, or amelloration of your cancer condition. It is further understood that the doctor/clinic are not communicating a guarantee or implied "cure" of your cancer status. I further understand that the advice and/or treatment the doctor/clinic is providing me is for general health care support, self-healing, and not for a specific disease or diagnosis. I also understand that some of the nutritional, herbal, metabolic supplements and ancillary procedures may be classified as experimental and developmental in nature, and that there may be no scientific proof that these suggestions will create the desired effect(s). I also understand there could be side effects/symptoms as a result of a suggested treatment(s).

I have read the explanation above of health care treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I hereby give my full consent to diagnostic testing and treatment. I understand that treatment and results are not guaranteed.

Printed Name Signature Date

Patient Billing Acknowledgement Form
Non-covered/Reduced Fees

Under your health plan/auto insurance you are financially responsible for co-payments, co-insurance, deductibles and auto reductions for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

These services are for exams, manipulation, muscle testing, therapies, and taping.

****

I ______________________, acknowledge that I have been told in advance
Patient Name –Print
by my provider that the services listed above are not covered/or may be reduced by my health insurance/auto insurance. I agree to pay for these non-covered/reduced services.

______________________________ ______________
Patient/Guardian Signature Date

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Health for Living Chiropractic, PC
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ATTENTION!

For the health and safety of our patients with Allergies/Asthma/Emphysema, please refrain from wearing any of the following on the day of your office visit:

- Cologne
- Perfume
- Scented Soaps
- Scented Lotions
- Scented Fabric Softeners
- Hair Spray

Thank you for your cooperation in this very important matter.