

Name:				Date:		
Address:			City:	_ State:	_ Zip:	
Phone: (Home) (Cell)			_ would you like to opt-in to text reminders? Y / N			
Email Address:				Date of B	sirth://	
Height:	Weight:	A	ge:	Gender Pronoun:		
Occupation: Employer's Name:						
Active Military/Veteran: YES NO – Which branch/years:						
Single / Married / Widowed	d / Partnered – N	ame:				
Pregnant?YES	_ NO Number of	Children:	Names & Ages: _			
Who may we thank for refe	erring you in?					
Emergency Contact: Phone: Relationship: Phone:				e:		
	PL	EASE LIST YOUR H	HEALTH CONCERNS			
Health Concerns: List Main Concern First	Rate Severity 1= Mild 10= Unbearable	When did this episode start?	Did you have this condition before? When?	Did the proble begin with an injury?	em Constant? Intermittent?	
Since these complaints/cor	ncerns started. ar	e thev:				
ABOUT THE SAME GETTING BETTER GETTING WORSE						
What makes it worse?						
What makes it better?						
What are these concerns keeping you from doing?						
Have you seen any other doctors/ health providers for this condition?						
Chiropractor Me			lical Doctor	0t	ther	
If so, WHO & WHEN: _						

List SURGERIES (if any) and dates:		
List all MEDICATIONS you are currently taking:		
When was your last Auto Accident?		
Have you ever been knocked unconscious?YESNO		
Fractured any bones?YESNO – If YES, please describe:		
Any other bodily trauma:		

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES	ULCERS	BLADDER PROBLEMS	LUPUS
VERTIGO	CHEST PAINS	IRRITABLE BLADDER	FYBROMYALGIA
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD / ADHD
ALLERGIES	ARM PAIN	LEG NUMBNESS	GERD
ТМЈ	HAND NUMBNESS	FEET NUMBNESS	ANXIETY
NECK PAIN	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
MIGRAINES	HEART DISORDERS	HIP PAIN	EPILEPSY
STIFFNESS IN NECK	MID BACK PAIN	LEG PAINS	DISC PROBLEMS
CHRONIC SINUS	STOMACH DISORDERS	KNEE PAIN	INFERTILITY
THROAT ISSUES	NAUSEA or REFLUX	LIVER DISEASE	OTHER
THYROID ISSUES	HIGH BLOOD PRESSURE	MENSTRUAL ISSUES	

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE - CANCER - HEART DISEASE - SPINAL SURGERY - SEIZURES - SPINAL FRACTURE - SCOLIOSIS – DIABETES
Are you interested in tracking your emotional well-being while in care at The Source Chiropractic? YES NO
What are your expectations with care at The Source Chiropractic?

PRINT NAME

SIGNATURE

DATE

EMOTIONAL HEALTH AND WELLBEING

Below are some statements about feelings and thoughts. Please circle the number that best describes your experiences of each over the last 2 weeks.

STATEMENTS	NONE OF THE TIME	RARELY	SOME OF THE TIME	OFTEN	ALL THE TIME
I've been feeling optimistic about the future.	1	2	3	4	5
l've been feeling useful.	1	2	3	4	5
I've been feeling relaxed.	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare.	1	2	3	4	5
I've been dealing with problems well.	1	2	3	4	5
I've been thinking clearly.	1	2	3	4	5
I've been feeling good about myself.	1	2	3	4	5
I've been feeling close to other people.	1	2	3	4	5
I've been feeling confident.	1	2	3	4	5
I've been able to make up my own mind about things.	1	2	3	4	5
I've been feeling loved.	1	2	3	4	5
I've been interested in new things.	1	2	3	4	5
I've been feeling cheerful.	1	2	3	4	5

Warwick-Endinburgh Mental Wellbeing Scale (WEMWBS)

NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

Please read each item and circle the number which comes closest to how you have been feeling in the past 2 weeks. Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long thought

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, and dizziness. Some of these symptoms are similar presentations to people experiencing a stroke; if you have a history of strokes or think you may be experiencing one, please let us know immediately.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
	Consent to Evaluate and Adjust a Mino	r Child
	being the parent or legal guardian of formed Consent and hereby grant permission for	
Print Name	Signature	Date
	Pregnancy Release	
•	est of my knowledge I am not pregnant, and the a x-ray evaluation. I have been advised that x-rays	
Date of last menstrual cycle:		
Print Name	Signature	Date

The Source Chiropractic No Call, No Show Cancellation Policy

Here at The Source Chiropractic, we understand that life can throw us unexpected emergencies. These unanticipated things are not always within our control. Due to appointments being in high demand, we ask that you do your best to notify us in advance about any changes to your appointment. It is our commitment to you as a Source member that you have an exceptional experience here at our office. Out of respect for our chiropractors and other Source members, we appreciate at least 24 hours advanced notice from our practice members when they are unable to keep their scheduled appointment. This is valuable time that can be dedicated to someone who may have an immediate need for care.

I understand:

• If I have not shown up within 15 minutes past my scheduled appointment and have not notified the office, it will be considered a No Call, No Show Cancellation. In this case, I will be charged 50% of my appointment cost.

• My care plan payments do not cover payment for missed appointments; therefore, I am responsible for these additional charges when applicable.

• Optional reminder texts, emails, and/or calls can be made 24 hours prior to my appointment, as a courtesy, and that I am expected to be in attendance of my appointment.

I authorize The Source Chiropractic to use the credit card I have on file for these additional charges when applicable.

To reschedule your appointment, please call 520-344-9651. If you are unable to reach us, please leave a detailed message on our voicemail system available 24 hours a day, 7 days a week. You may also cancel via email: sourcechirotucson@gmail.com.

Thank you for your understanding. We are available to answer any questions you may have. We look forward to caring for you here at The Source Chiropractic!

I have read and agree to the terms of The Source Chiropractic's No Call, No Show Cancellation policy.

Print Name

Signature

Date

Office Staff: _____