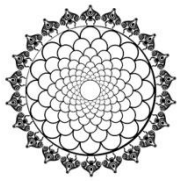


Flow Chiropractic & Family Wellness Center

PLEASE TELL US ABOUT YOURSELF

The Basics

Name (last)_____ (first)_____ (mi)_____ Sex: M / F / Other

Home Address (street)_____(city)_____(state)_____(zip)_____

Home Phone (____)_____ Mobile (____)_____ E-mail_____

Would you like to receive our email newsletter/events/promotions (a few times per year)? Yes___ No___

Date of Birth: ___/___/____ Age_____ Height_____

Occupation_____ Employer_____ Do you enjoy what you do? Yes___ No___

Are you in a Relationship? Boyfriend/Girlfriend___ Married___ Partnered___ Divorced___ Widowed___ Separated ___

Spouse/Partner's Name (if you have one) (last)_____ (first)_____

Do you have any children? No, and I'm OK with that ___ No, but I would like to have children___ Yes, and I am happy with how many I have___ Yes, and I would like to have more___ Undecided___

Number of Children_____ Names and Ages_____

Are you currently trying to become pregnant? Yes___ No___ We're not trying, but we're not not-trying___

Emergency Contact_____ Phone (_____)

What Brings You Here?

General Wellness___ Preventative Care___ Curiosity/New experience___ Referred by another practitioner___

Who referred you? (MD, ND, Lac, DC, OB, Midwife, Family/Friend)_____

What are your health concerns?_____

_____

_____

If you have a specific concern, when did it first begin? _____

Have you done anything for, gotten advice for, or sought treatment for this issue? Yes___ No___

Explain:_____

Result:_____

Is this condition worse during certain times of the day or with certain activities? Yes___ No___

When?_____

What does it negatively impact? Work___ Relationships or intimacy___ Decision-making___ Exercise or play___
Attitude, mood, patience___ Ability to relax or sleep___ Day-to-day activities___

Do you have any other concerns about your health and well being? No___ Yes___ (Explain) _____

_____

Have you been to a chiropractor before? Yes___ No___ If yes, where and who?_____
When were you last adjusted?_____ Did you enjoy the experience?_____

Your Developmental History (Before Birth to 18 years) Adopted?___

Your Mom's Pregnancy with YOU involved: Tobacco___ Alcohol___ Medications___ Recreational Drugs___ Falls/injuries___
Abuse___ Stress___

Details of checked:_____

YOUR Birth:
Hospital___ Home Birth___ Vaginal___ Cesarean (C-section)___ Vacuum/Suction___ Forceps___ Induced___

Complications___ Details:_____

Were you isolated or incubated after birth? Yes___ No___ If yes, how long?_____

Childhood (Age 0-18):
Breastfed___ Formula fed___(Dairy / soy?) Vaccinations___(All / modified?) Surgeries___ Medications___ Physical Abuse___

Sexual Abuse___ Bullying/teasing___ Loss of loved ones___ Accidents/falls/injuries___ Dislocations/fractures___

Nightmares/night terrors___ Frequent relocation/moving___ Special diet___

Details of any checked:_____

_____

Adult History (18 years old until today):
Do you: Smoke (tobacco)? No___ Yes___ If yes, how much/day?_____

Drink alcohol? No___ Yes___ If yes, how much/day?_____

Exercise/Move Daily? No___ Yes___ What do you like to do?_____

Meditate/Pray/Get into Nature? No___ Yes___

Sleep well? No___ Yes___ How many hours per night?_____ Do you nap daily? No___ Yes___

Any digestive issues?_____

How often do you have a bowel movement?

3+times/day___ 1-2 times/day___ Every other day___ Two or less per week___ Varies a lot___

How much water do you drink each day? 1-3 glasses____ 4-7 glasses____ 8+ glasses____

What color is your urine most often? Amber/brown___ Dark yellow___ Light yellow___ Clear___ Pink___

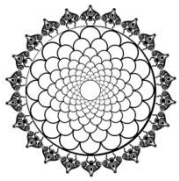
The body is designed to be healthy. Throughout life, events and experiences can occur which may have negatively affected your body's expression of health. The following questions will help uncover possible types of input that may impede your body's ability to fully express your health potential. The science of Chiropractic revolves around the detection and release of nerve interference and tension patterns stored in the spine and throughout the body called subluxations. Subluxations are caused by physical, chemical, and emotional stresses to which the body cannot adapt. In order to understand the current state of your health, please be as thorough as possible with the following information.

Mark all that apply with N for Now and P for Past

Physical Stress		Emotional Stress	Chemical Stress
__Weight gain/loss	__Allergies/sinus trouble	__Anxiety	__Environment
__Cancer	__Numbness/tingling	__Depression	__2nd hand smoke
__Stroke	__Asthma/breath issues	__Relationships	__Caffeine
__Neck/back pain	__High blood pressure	__Career	__Alcohol
__Dizziness/vertigo	__Frequent colds/flus	__Family	__Diet/sugar free food
__Slip/fall	__Skin Conditions	__Financial	__Junk food
__Concussion/head injury	__Headaches/migraines	__Pace of life	__Soda intake
__Sports injury	__Menstrual problems/pain	__Quick temper	__Prescription drugs (list below)
__Heavy physical labor	__Dental/jaw issues	__Holding in feelings	
__Poor posture	__Thyroid disorder	__Perfectionism	
__Heavy computer use	__Digestive problems	__Procrastination	
__Repetitive movements	__Bowel/bladder changes		
__Heavy driving/standing	__Abuse (physical, sexual, or emotional)		
__Motor Vehicle Accident	__Surgeries (list below)		
__Fractures			

Please elaborate on any checked_____

_____



Female History (if you are not a woman, you can skip this):
Regarding your own menstrual cycle/pregnancies/births:
Age of first period____ Average cycle length____ Irregularities____ Pain/cramps____ Clots____ PMS____

Birth Control: None___ Pill___ Ring___ Implant___ Condom/barrier___ NFP/FAM___ Other_____

Have you ever been pregnant? No___ Yes___ Had a miscarriage or abortion? No___ Yes___

If you've delivered a baby: (Check regarding most recent delivery; we will talk about all other deliveries.)
How many babies have you birthed?____ How many are currently living with you at home?____

Third Trimester Presentation: Head down + Vertex___ Head down + Face/brow___ Breech___ Transverse___

Type of Birth: Vaginal___ C-section___ VBAC___ Hospital___ Birth Center___ Home Birth___

Birth Team: OB___ Midwife___ Doula___ Partner-Assisted___ Family present___

Interventions: Pitocin___ Epidural___ Ruptured Membranes___ Episiotomy___ Assisted pushing___
Suction cup or Vacuum___ Forceps___ Medications___ Restricted movement during labor___

If you are currently pregnant: How many weeks along are you?_____

Planned Birth Location: Home___ Birthing Center___ Hospital___(which one?)_____

Birth team: OB___ Midwife___ Doula___ Partner-Assisted___ Family present___

Names of OB, Midwife, and/or Doula:_____

How long do you plan to breastfeed?

I don't plan to breastfeed___ 0-2 months___ 0-6 months___ 6-12 months___ 1 year___ 1-2 years___ Self-led wean___

What are your vaccination plans for the baby?

I choose not to vaccinate___ Modified/selected schedule___ Delayed schedule___ Full schedule___ Unsure___

Financial Information: Who is responsible for this account with Flow Chiropractic? _____

Ariel Provasoli DC does not offer to diagnose or treat any symptom or disease condition. Our sole purpose is to analyze your system for Subluxation patterns and to help your body release them so it can more fully express its innate ability to heal. Wellness is a dynamic equilibrium between health and disease. It exists when all organs of the body function at 100% under the direction of the nerve system and the Inborn Intelligence of the body. If during your assessment a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider to serve you.

I, _____ , have answered the above questions to the best of my knowledge. Based on the information provided, I grant Ariel Provasoli DC permission to assess, locate, and release my subluxation patterns.

Your signature _____ Date_____

Terms of Acceptance / Philosophical Agreement

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

- There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
- The Nerve System is the main coordinating and distribution system for the body's innate intelligence.
- Alterations or distortion in the shape, position, tone, or tension of the Nerve System (especially at the spine) will interfere with the expression of this intelligence.
- Chiropractors call this interference to the proper functioning of the Nerve System a Vertebral Subluxation. Subluxation causes alternation in nerve function and distorts the communication channels between the brain and the body. The result is a lessoning of the body's ability to express its maximum health potential.
- Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.
- An Adjustment is the specific and honoring application of forces to facilitate the body's release and integration of subluxation.
- The sole purpose of the chiropractic adjustment in this office is to assist your body to release vertebral subluxation and benefit from the restoration of clear communication channels in the body. Everyone, regardless of their age, symptoms or ailments, will benefit from a nerve system which is more flexible, elastic, and free of vertebral subluxation.
- Chiropractic is not a substitute, an alternative or a preventative form of medicine. We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body's innate wisdom and to support your body to hold and integrate adjustments and healing. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.

I, _____, have read the above statements and understand the doctor's objectives pertaining to my care in this office. 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 and acceptance and hereby grant permission for my child to receive chiropractic care in this office.

Signature

Flow Chiropractic & Family Wellness Center

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, Craniosacral therapy and subtle energy rebalancing and supportive therapies on me (or on the person named below for whom I am legally responsible) by Ariel Provasoli, DC or any doctors of chiropractic working or associated with or covering at Flow Chiropractic and Family Wellness Center.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, sprains, fractures, disc injury, stroke and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions and ultimately improve health. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust joints and release muscles, which may cause an audible “click” or “pop” during the procedure.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for adjustment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and can secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness to Patient’s Signature

Flow Chiropractic & Family Wellness Center

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Flow Chiropractic's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for FC to provide treatment to me, and necessary for FC to obtain payment for that treatment and to carry out its health care operations. FC explained to me that the Privacy Notice will be available to me in the future at my request. FC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.

2. FC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law and I will be informed of any revisions.

3. I understand that, and consent to, the following communications that will be used by FC: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me. [Please note: email and text messages are not secure, protected forms of communication. By signing below you are acknowledging your choice to use them to communicate PHI.]

4. FC may use and/or disclose my PHI in order for FC to treat me and obtain payment for that treatment, and as necessary for FC to conduct its specific health care operations.

5. I understand that I have a right to request that FC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, FC is not required to agree to any restrictions that I have requested. If FC agrees to requested restrictions, then the restriction is binding on FC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the FC has already taken action in the reliance on this consent.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, FC will not treat me. I further understand that if I revoke this consent, at any time, FC has the right to refuse to treat me.

8. FC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in FC's practice.

9. Visits and spinal adjustments are performed in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. If you have comments or information you wish to share privately when you come into the adjustment room please inform the doctor or staff and we will accommodate your needs.

I acknowledge that I have received a copy of FC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer, Ariel Provasoli. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____ _____

Patients 's Name (printed) Date Signed

_____

Signature (patient or legal representative)