COLLEEN SWEENEY, D.C.

FIRST VISIT FORM

Date: ____ /_____ /_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Birthdate: ____/____/_____ Occupation: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Do you have children? Yes ___ No ___ How many? _____ Names and ages if under 18:

_____

Whom may we thank for referring you or how did you hear about us?

_____

Reasons for seeking service: _____

When did you last see a Chiropractor? _____ Dr. _____

PHYSICAL STRESS

Have you had any accidents, falls, or traumas? Please describe: _____

_____

_____

Have you had any surgeries? Please describe: _____

_____

Have you had any illnesses or diseases? Please describe: _____

_____

Birth trauma often causes the first subluxation. Was your own birth a difficult one?

Please describe: _____

Is your body subjected to stressful repetitive activities at home or at work (keyboarding, painting, crossing legs, sitting, driving, carrying children, etc.)? Please decribe: _____

_____

_____

What sports or exercise do you enjoy? _____

_____

_____

Do you regularly practice yoga, stretching or another form of movement to increase your flexibility? _____

_____

What is your level of physical activity? Low _____ Moderate _____ High_____

CHEMICAL STRESS

Circle your intake (Z=Zero, L=Low, M=Med, H=High) of:

Meat/Protein	Fruits	Vegetables	Breads/Grains	Dairy Products	Oils/Fats
Z L M H	Z L M H	Z L M H	Z L M H	Z L M H	Z L M H

How often do you use the following:

Sugar	Pop	Coffee	Tea	Alcohol	Tobacco
Z L M H	Z L M H	Z L M H	Z L M H	Z L M H	Z L M H

Do you take any medications or drugs? Which ones, and for how long? _____

_____

_____

Do you take any nutritional supplements? _____

Do you have any allergies? _____

_____

EMOTIONAL STRESS

Please rate the level of stress in your life in these areas? (L=Low, M=Medium, H=High)

Home _____ School _____ Work _____ Relationships _____ Children _____

Family _____ Friends _____ Loss of loved one _____ Divorce _____

Separation _____ Finances _____ Health _____

Write the one word you would use to describe yourself: _____

Is there anything else I should know about you? _____

_____

_____

_____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office along with your rights concerning those records. Before we will begin any health care services, we require you to read and sign this consent form stating 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 PHI, we encourage you to read the HIPPA NOTICE, which can be made available at your request, before signing this consent form.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of the adjustment, payment, heath care operations, and coordination of care.

2. The patient has the right to 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 PHI. Our office is not obligated to agree to those restrictions.

3. The patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. For your security and right to privacy, all staff members have been trained in the area of patient record privacy. We have take all precautions to assure that your records are not readily available to those who do not need them.

5. If the patient refuses to sign the consent for the purpose of adjustment, payment, and health care operations, the chiropractic doctor has the right to refuse care. I have read and understand how my PHI will be used and I agree to these policies and procedures.

Signature:_____ Date: ____ /_____ /_____

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

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FEE STRUCTURE

First Visit.....**$175**

A personal evaluation of your spine, nerve system, and lifestyle followed with specific chiropractic adjustments.

Adjustments.....**$70**

Adult & child (under age of 10) adjustment.....**$100**

Each additional child.....**$30**

A blend of precise structural, energetic, and meningeal adjustments to release stored life potential.

PRE-PAID PACKAGES

Individual – 10 visits.....**$630**

(10% discount)

Families.....**Receive a 10% discount.**

If you must cancel an appointment, please call 24 hours ahead to avoid cancellation fees.

Payments can be made online through the scheduling site. Payment is due at the time of service. Cash, checks and credit cards are accepted. Please make checks payable to Innergy, LLC. If you wish to be reimbursed by your insurance, I will provide you with a receipt to submit. Your insurance coverage is a contract between you and your insurance company. I do not file directly with your insurance company and reimbursement is your responsibility.

COLLEEN SWEENEY, D.C.

PHILOSOPHICAL AGREEMENT

Innergy, LLC exists to make a positive contribution to people's lives and to our community by assisting individuals in a greater expression of life. Life is the essence of what sustains us from the moment of conception until our last breath. Life creates, recreates, adapts, and allows for well being and healing.

As part of daily living, we are exposed to many stresses: physical, mental, emotional, or chemical. When we are unable to adapt to these stresses, tension, torsion, or misalignment of the structures of the spinal column occur. This causes interference to the delicate communication between our nerve system and our other body system including musculo-skeletal, immune, respiratory, cardiovascular, digestive, and many others.

Chiropractic adjustments allow your body to release the stored tension along your spine, called subluxation, facilitating a free flow of vital information essential for all human functions, including body functions, emotions, creativity, performance, and spiritual expression. You may experience changes in many areas of your life – physical, emotional or spiritual from the release of subluxations. In some people, these changes are rapid and dramatic. In others, they may be subtle. At some level, everyone benefits from the release of subluxations.

Chiropractic care specializes in the restoration and expression of life. It is not a form of medicine. Medicine specializes in the treatment of disease. It is not my goal or intention to diagnose, treat, or attempt to cure any physical, mental or emotional ailments, or to give advice about medical conditions. If you become concerned about symptoms or disease I suggest you seek the services of a symptom- and disease-care professional.

My objective is simple: to correct subluxations allowing you maximum expression of life.

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

Signature:_____

If a minor, print child's name:_____

I, as the parent or legal guardian, have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

Signature of guardian:_____

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