

Life Chiropractic/Back In Action

Bruce D. Stevens D.C.

217-A West Central, Lompoc CA 93436 • 805-737-5656

Name: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Date of Birth: _____ SSN: _____

Drivers License or ID #: _____ State: _____

Single Married Divorced Widow Number of Children _____

Are you pregnant Yes No Height: _____ Weight: _____



Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext: _____



Are you covered by health insurance? Yes No

**If yes, please give your card to the Front Desk so they may get a copy.*

Name of Insurance: _____

Subscriber's name: _____ Subscriber's DOB: _____

Member/ID #: _____ Relationship: _____

Subscriber's Employer: _____



Is this injury work related? Yes No

Is this injury a result of an Auto Accident? Yes No

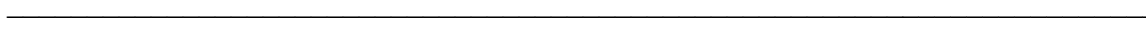
**If you answered yes to either of the above questions please let the Front Desk know immediately.*



How were you referred to our office? _____

Have you ever had chiropractic care before? Yes No

If yes, when and where? _____



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Please list your chief complaints in order of severity (pain, symptoms, etc)

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Please list other doctors consulted for this condition: N/A

1. _____
2. _____

How did this condition develop? What caused it? (fall, lifting, etc)

Date on injury: _____

Has this problem been getting Better Worse Staying the same

Is there anything you do that makes your condition worse? Yes No

If yes, please list: _____

Have you ever had any surgery/hospitalizations? Yes No

If yes, please list: _____

Please list injuries or illness that you have had in the past that are not listed above:

Medication you now take Aspirin/Tylenol Painkillers Muscle Relaxers

Tranquilizers Insulin Birth Control Pills

Other (please list) _____

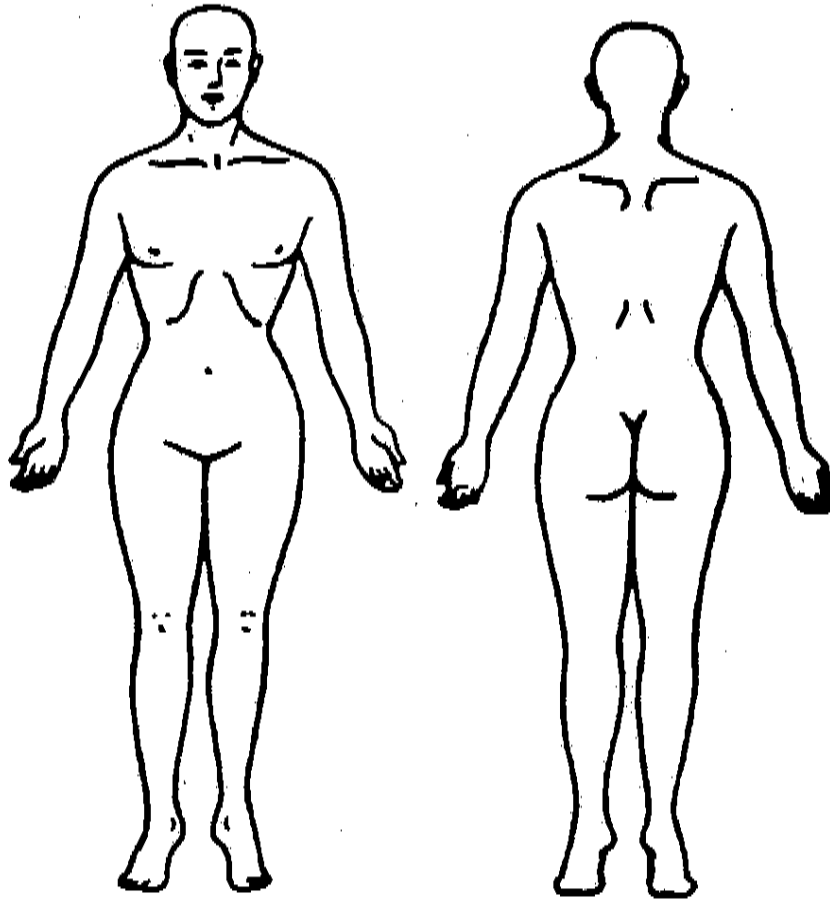


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If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity that brings on or aggravates the pain. For example, is it dull, sharp, constant, off and on, when standing, when sitting, etc.

Complete These Diagrams



Method of payment you plan to use for today's charges Check Cash Credit Card Special

Notice: *Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment. If your examination warrants x-ray analysis, the following office policy prevails:*

1. All first-visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for the purpose of analysis, they cannot be released.

Patient Signature _____ Date _____



Life Chiropractic

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 toward the same objective. Chiropractic has only one goal: to detect and correct/reduce the vertebral subluxation complex. 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 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 caused alteration of nerve function and interference 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 disease or a condition other than vertebral subluxation. Regardless of what 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.

NOTE: It is understood and agreed the amount paid to Life Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Life Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read, understand and hereby request chiropractic care based on the above agreement.

Date _____ Signature _____

Signature of parent or guardian if minor _____