

Let's Find Out Why You're Here...



Reason for seeking chiropractic care: _____

Any other specific concerns? _____

List all current medications and conditions being treated: _____

List any past surgeries and dates: _____

List any past accidents and dates: _____

List any injuries: _____

Has your child ever been under chiropractic maintenance care? _____

Do you know what a subluxation is? If yes, please describe: _____

Health Inventory

If your child has experienced any of the following, please indicate by writing:
C (Current), **P** (Past) or **CP** (Current and Past).

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Chronic ear infections/earaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Serious fall(s) or repetitive falls |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Head injury | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Illnesses with a high fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Serious illness | <input type="checkbox"/> Difficulty focusing | <input type="checkbox"/> Trouble with bladder control |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Joint or muscle problems |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Neck or back problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Low energy/tired | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Allergies to foods | <input type="checkbox"/> Adverse reaction to any vaccinations |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Cancer | <input type="checkbox"/> Environmental allergies | Other: _____ |

Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function *is* increased **health, wellness** and an **overall improved quality of life**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Tye Moe to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Moe to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed _____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!

