



Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell \_\_\_\_\_  
 Email \_\_\_\_\_ Birthday! \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital/Relationship Status \_\_\_\_\_ Spouse/Partner Name \_\_\_\_\_  
 Names & Ages of all Children \_\_\_\_\_

Reason for seeking our services? \_\_\_\_\_

What other action steps have you taken? \_\_\_\_\_

Who can we thank for referring you to **Waltz Family Chiropractic**? \_\_\_\_\_

Have you ever been adjusted by a Chiropractor? \_\_\_\_\_ Who and Where? \_\_\_\_\_

Date of last adjustment? \_\_\_\_\_

Do you have a Primary Care Provider? \_\_\_\_\_ Who and Where? \_\_\_\_\_

Many of the health challenges that people face originate from stressors experienced during developmental and adult years. These stressors (traumas) may be emotional, mental, physical, or chemical. Our goal is to help your body release stored/deep tensions and the more we know about you, the more we can help you with your healing process. *Please answer all of the following questions to the best of your ability.*

**Birth history** (if known, please indicate all that apply to your own personal birth experience):

- mother smoked/drank/drugs while pregnant
- vacuum extraction
- forceps delivery
- C-section
- epidural/meds in labor
- induced labor
- hospital birth
- home birth
- midwife
- doula
- breast-fed
- bottle-fed formula

**History of Physical Stress, Trauma or Challenges**

- repetitive lifting /bending /typing
- work injury
- sit a lot/traffic
- car accidents
- surgeries
- hospitalizations
- serious falls
- active in sports
- sit on wallet
- no exercise
- alcohol or drug abuse
- not enough/poor sleep
- physical abuse
- broken bones
- other injuries \_\_\_\_\_

**History of Chemical Stress, Trauma or Challenges**

- smoker past/present
- poisoning
- vaccinated
- alcohol use
- work with chemicals
- caffeine/sugar/artificial sweetener
- drug use
- over the counter meds
- prescription medications
- drug/alcohol overdose
- antibiotics
- poor diet
- other \_\_\_\_\_

**History of Mental/Emotional Stress, Trauma or Challenges**

- recurrent physical/mental illness
- hold in feelings
- quick tempered
- made fun of/teased
- loss of loved one
- high family stress
- body image issues
- not valued
- high personal stress
- mental/emotional/sexual abuse
- alcohol or drug abuse
- high job stress
- physical abuse
- money stress
- difficult divorce/break-up
- other \_\_\_\_\_

**Nutritional History** (please check the items that apply to your typical diet)

- junk food (\_\_\_ x's per week)
- microwave food (\_\_\_ x's per week)
- gluten-free
- vegan
- other special diet \_\_\_\_\_
- excess sugar
- artificial sweetener
- dairy-free
- omnivore
- skip meals
- no breakfast
- vegetarian
- raw food

- water (# of glasses per day \_\_\_\_)
- soda
- caffeine
- alcohol
- energy drinks
- tea/coffee
- juice

Do you relate any of the experiences checked above to your current state of health?  Yes  No  
If yes, which ones? \_\_\_\_\_

**Has your body communicated any of the following to you?** (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

- Headaches
- High Blood Pressure
- Low back pain
- Neck Pain
- Ringing in Ears
- Rashes/Eczema
- Sinus problems
- Mood Swings
- Allergies
- Chest pain
- Dizziness
- Cancer
- Fatigue
- Asthma
- Loss of sleep
- Heartburn
- HIV
- Vertigo
- Anxiety
- Sweats/Chills
- PMS
- Fever
- Arthritis
- Anemia
- Shortness of Breath
- Loss of smell or taste
- Stomach Problems
- Heart Conditions
- Weight Changes
- Urinary Changes
- Digestions Problems
- Other \_\_\_\_\_
- Tension across top of shoulders
- Tension between shoulder blades
- Numbness in Arms/Legs
- Depression/Nervousness
- Constipation/Diarrhea/Gas
- Cold Hands/Feet
- Diabetes

**For women:**

- past pregnancy
- birth control pills/patch/ring
- currently pregnant
- painful periods
- breast-feeding
- irregular cycles

**Have you had or do you use any of the following for your growth, healing and development?**

- Massage/Bodywork
- Emotional Therapy/Psychotherapy
- Physiotherapy/Occupational Therapy
- Music/Dance/Sound/Light/Aromatherapy
- Yoga/Pilates/Dance/Tai Chi
- Homeopathy/Herbalist
- Naturopathic Medicine
- Ayurvedic Medicine
- Acupuncture
- Cranial-Sacral
- Nutritional Cleansing
- Nutritional Counseling
- Breathwork/Re-birthing
- Feldenkrais
- Other \_\_\_\_\_

Are you currently taking any medications (prescribed or over the counter)? Please list here.

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## Clarifying Your Intentions

What do you hope to receive from our care? (i.e. full, abundant health and well-being, pain relief, reconnection of my spiritual/physical body, etc.)

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What is your level of commitment to yourself, your life and well-being? **Low** 1 2 3 4 5 6 7 8 9 10 **High**

# Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.

1 = extremely dissatisfied. 10 = completely fulfilled.

Energy level \_\_\_\_\_

Clarity of thought \_\_\_\_\_

Physical Flexibility and Ease \_\_\_\_\_

Mental Flexibility \_\_\_\_\_

Emotional balance \_\_\_\_\_

Level of pain \_\_\_\_\_

Sleep quality \_\_\_\_\_

Connection to spirit/source \_\_\_\_\_

Feelings of abundance \_\_\_\_\_

Level of joy in life \_\_\_\_\_

Relationships \_\_\_\_\_

Sense of Peace \_\_\_\_\_

Ability to adapt to change \_\_\_\_\_

Overall health and wellbeing \_\_\_\_\_

**Privacy Statement:** The information you provide on this form is confidential. We will provide you and designated family members with this information by request only and will not use it for any purpose other than to aid us in providing you with the highest standard of wellness care that we are capable of giving. We appreciate your time and commitment to your ongoing health and well-being.

**Authorization for Care**

I hereby authorize the Chiropractor(s) to work with me through the use of adjustments to my spine, as he or she deems appropriate. In this office we do not treat symptoms and diseases. We offer true healing and greater life expression through chiropractic. The Chiropractor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The medical insurance industry pays for the treatment of symptoms and disease rather than the maintenance of our well-being. As chiropractic is not a treatment nor cure of disease, we require your "investment" to be paid directly to us at time of service. However, we will provide you with a form to submit your claims to your insurance company if you desire. Your insurance policy is between you and your insurance company, not between your insurance company and us.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I, \_\_\_\_\_, have completed this form to the best of my ability and have read the privacy statement and agree to the terms set forth by this office

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Spouse Authorizing Care

\_\_\_\_\_  
Date

*Our mission is to serve every human being with respect, compassion, gratitude, and love. We will strive to provide the exceptional chiropractic experience through the chiropractic adjustment and the teaching of our body's magnificent innate potential. We aim for excellence, mastery, and constant growth while enjoying the perfection of the process itself.*

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**Chiropractor's Notes:**  
(please leave blank)

# Understanding Our Service

**When a person seeks chiropractic care, it is essential for both the Individual and the Chiropractor to be working towards the same objective.**

In this office, chiropractic adjustments are delivered to free up Life Force, allowing every individual whether a newborn, an athlete, or a grandparent to express more health. **Health** is defined as the state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. **Adjustments** are specific applications of forces delivered to facilitate the body's correction of subluxations. **Subluxations** are patterns of tension stored in the body causing an alteration of nerve function and interference to the transmission of mental impulses (Life Force); the essential impulses that allow the expression of health, vitality, and personal expression.

Specific chiropractic adjustments deepen everyone's potential to heal biologically and at the core. In some, physical, emotional, mental, or spiritual challenges may clear up quickly, in others, the process is slower, and in some, it appears partial or not at all. Yet everyone will benefit from a properly functioning nerve system and greater life expression. Healing is a non-linear path, which means that one might experience ups and downs during a course of chiropractic care. This might include the experience of emotions, soreness, fatigue, and sensation awareness as subluxations are released and the body finds a new alignment. It also might mean greater energy, rest, ease, creativity, and connectivity.

**Chiropractic is not a substitute, an alternative or a preventative form of medicine.**

Chiropractic specializes in the expression of life, wellness, healing and well being, whereas medicine specializes in the diagnosis and treatment of symptoms, sickness, and disease. It is not Dr. Kara Waltz's goal or intention to diagnose, treat, or attempt to cure any physical, mental, or emotional ailments. The only diagnosis made in this office is that of subluxations. However, if during the course of chiropractic care non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire advice, diagnosis, or treatment for those findings, the chiropractor will recommend that you seek the services of another health care provider.

I, \_\_\_\_\_ the undersigned, have completely read and understood the above statements and choose to be served by Dr. Kara Waltz with this understanding for myself. All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or Guardian (for anyone under the age of 18)  
\_\_\_\_\_ Date \_\_\_\_\_

