When a person seeks chiropractic care and I accept such a patient for care, it is essential for both to be working towards the same objective. ***Chiropractic has only one goal.*** It is only when the patient understands both the objective and the method that they will be able to attain it -- this will prevent any future confusion or disappointment.

The only code we offer is **S8990** for the correction of VERTEBRAL SUBLUXATION for maintenance of health, not restoration. Therefore, we do not accept insurance NOR create forms for 3rd parties.

An **ADJUSTMENT** is the specific application of force to the spine to correct a subluxation <— this is the only goal of chiropractic.

HEALTH is a state of optimal physical, mental, social, and spiritual well-being, not merely the absence of dis-ease.

VERTEBRAL SUBLUXATION is a misalignment and fixation of one or more of the bones/joints of the spine that cause internal neurological stress. This ***may*** cause pain ***OR*** absolutely NO symptoms at all ***BUT ALWAYS*** causes alteration in autonomic function ***&*** alteration of neurological flow into and out of the central nervous system, lessening the body's innate (God-given) ability to maintain maximal health. You may be at an increased risk including but not limited to headaches, aches and pains, or risk of any cardiovascular events with prior mRNA vaccines.

A **DIAGNOSIS** is the identification of the nature of an illness or other problems by examination of symptoms.

Since subluxation can be present without symptoms, it (subluxation), in essence, is NOT a diagnosis. We do not offer to diagnose or treat any symptoms or conditions. Our only objective is to DETECT and CORRECT vertebral subluxations and eliminate major interference to the expression of the body's innate wisdom. Our method includes adjusting subluxation and lifestyle education to Move Well, Eat Well and Think Well (offered in orientation class) to minimize stressors that cause subluxation and to live **LIFE** Subluxation-Free or as close to it as possible.

By signing below, you have accepted the terms above.

_____ _____

Practice Member/Guardian Chiropractor

ABOUT YOU & YOUR FAMILY

NAME:
ADDRESS:
CITY/STATE/ZIP:
PHONE:
EMAIL:
GENDER: **M** / **F** D.O.B
MARITAL STATUS: **MARRIED** / **SINGLE** / **WIDOW**
NUMBER OF CHILDREN: _____

HOW MANY FAMILY MEMBERS WOULD YOU LIKE ON YOUR WEEKLY WELLNESS PLAN? _____
ANY SURGERIES? **Y** / **N** IF YES, EXPLAIN:
DO YOU SMOKE? **Y** / **N**
DO YOU DRINK ALCOHOL? **Y** / **N** IF YES, HOW OFTEN?

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU BEEN ADJUSTED BEFORE? **Y** / **N** IF YES, WAS IT FOR "SYMPTOM MANAGEMENT/PAIN RELIEF" OR FOR "BETTER EXPRESSION OF HEALTH"? EXPLAIN:
DEFINE "**HEALTH**":
DEFINE "**SUBLUXATION**":
WHAT IS THE **ONLY** GOAL OF CHIROPRACTIC?

LOVED ONES

NAME(S), PHONE #(S), EMAIL(S)	DOB:

NAME(S), PHONE #(S), EMAIL(S)	DOB: