CESCA FAMILY CHIROPRACTIC
1290 Baltimore Pike Suite 106
Chadds Ford, PA 19317

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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** The 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 vertebra in the spinal column which causes 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 diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's 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)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ _____
(signature) (date)

PATIENT INFORMATION

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Email: _____

Date of Birth: ___ / ___ / _____ Gender: Male / Female May we use email to communicate with you? Yes No

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #_____ Work Phone #: _____

Employer Name: _____ Occupation: _____

How did you hear about this office: _____

Height: _____ Weight: _____ lbs Marriage Status: Single / Married / Other

Current Medications: _____

_____

Allergies: _____

Smoking history: (please circle) Never / Current / Former Frequency: _____/_____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____

Date of Birth: ___ / ___ / _____ Phone #: _____

PRIMARY INSURED INFO: *(**Required, even if primary insured is not a patient of this office**)*

Last Name: _____ First Name: _____ DOB: _____

Insurance Company: _____ HMO: Yes No

Policy #: _____

Secondary Insurance Company: _____ HMO: Yes No

Policy #: _____

RESPONSIBLE PARTY: *(Complete this section if you are not the patient but are responsible for any payments.)*

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

PAYMENT METHOD: Cash Check Visa MasterCard

SIGNATURE: *(The above information is true and accurate to the best of my knowledge.)*

I request services X _____

(Patient, Parent, Legal Guardian or Responsible Party)

Patient Health Questionnaire - PHQ

Patient Name _____ Date _____

1. Describe your symptoms _____

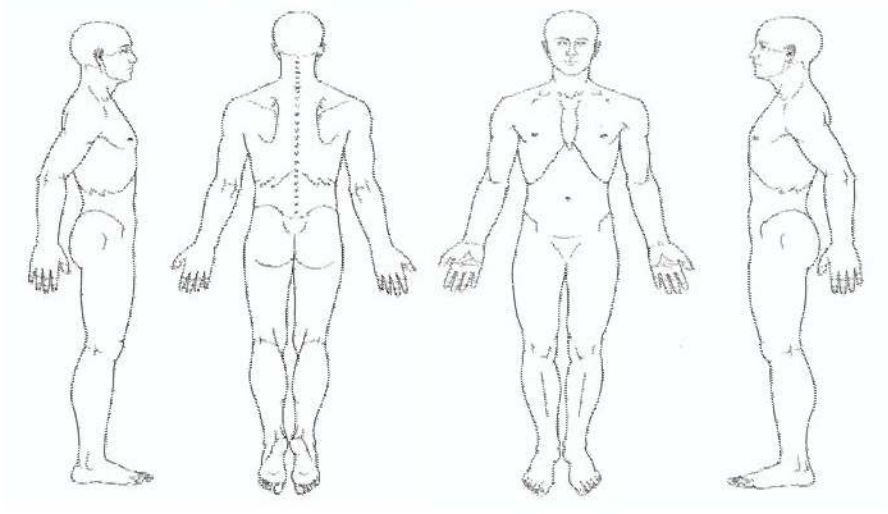
_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

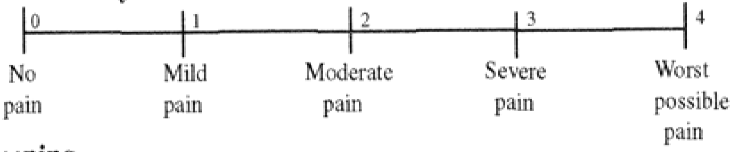
Patient Signature _____ Date _____

Functional Rating Index

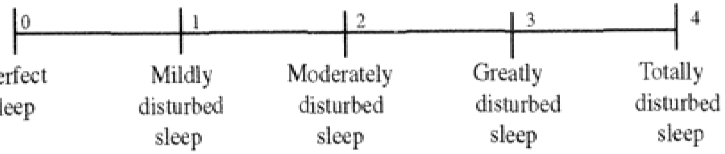
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

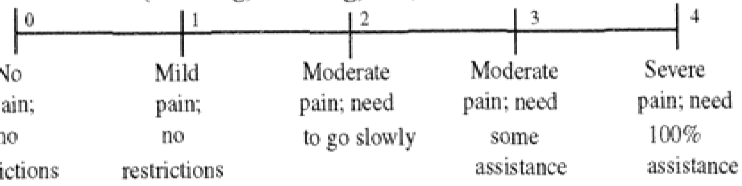
1. Pain Intensity



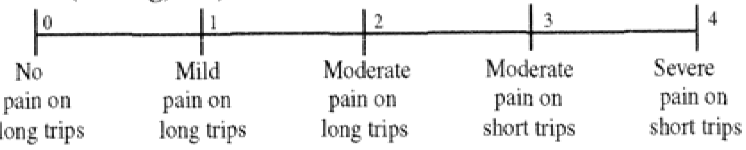
2. Sleeping



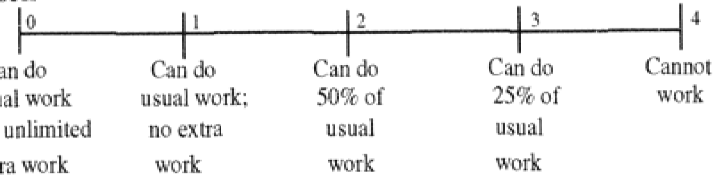
3. Personal Care (washing, dressing, etc.)



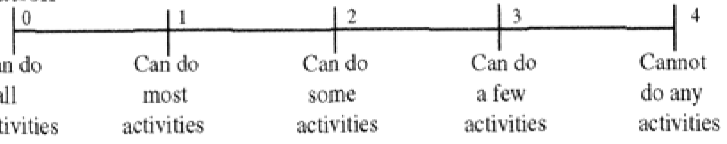
4. Travel (driving, etc.)



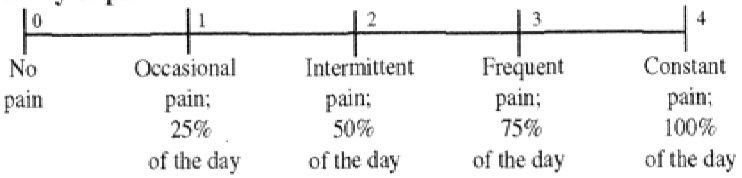
5. Work



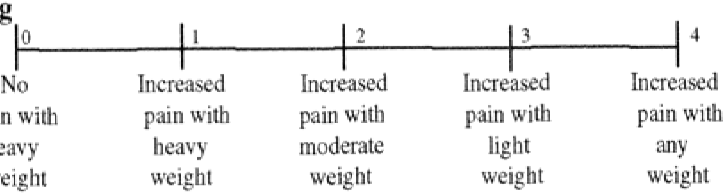
6. Recreation



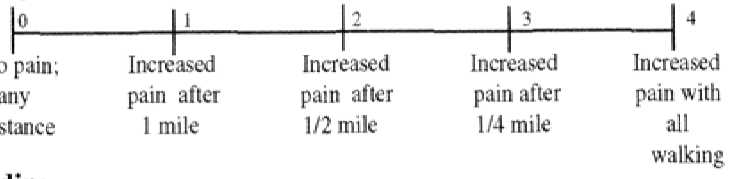
7. Frequency of pain



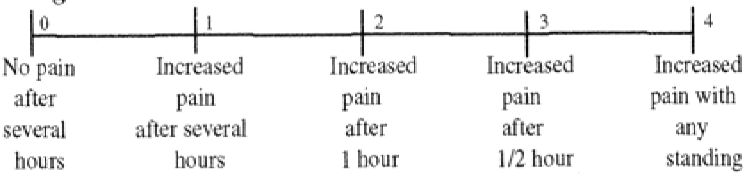
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date