PRAVO Wellness Centre

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262.502.0028
www.pravowellness.com

Please fill out this form as completely and accurately as possible.

Today's Date :

PERSONAL DATA

Name_____ Age _____ Date of Birth _____
Parents' names (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:_____
Names and ages of children _____
Emergency Contact: Relation-_____Phone_____
Whom may we thank for referring you to our office? _____
Social security **#: _____**

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Corrective Care Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work Y N	Driving Y N	Sleep Y N
School Y N	Walking Y N	Sitting Y N
Exercise/sports Y N	Eating Y N	Other Y N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑N Name of D.C._____
How long under care? ❑_____ days ❑_____ weeks ❑_____ months ❑_____ years
Date of last visit: _____Why did you stop?

_____

How was your experience?_____

Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

❑Medical Physician ❑Naturopath ❑Acupuncturist ❑Homeopath
❑Massage Therapist ❑Psychotherapist ❑Energy Healer ❑Dentist
Reason why: _____

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible/Unknown
If pregnant due date?_____ Name of OBGYN or Midwife:_____
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature:_____ Date:_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____
Does your job require regular airline travel and hotel stays? ❑Y ❑N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____
_____
How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N
Do you ever sleep on your stomach? ❑Y ❑N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel life? ❑Y ❑N If yes, for how many years? _____
Do you use a cervical pillow? ❑Y ❑N

PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? ❑Y ❑N C-section? ❑Y ❑N Forceps/vacuum ? ❑Y ❑N
Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____
_____
Have you had any **significant adult injuries**? Please list dates, injury and treatment:

_____
_____
Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

FAMILY HISTORY

___Arthritis ____Asthma ____Back Pain ____Cancer ____Depression ____Diabetes ____Epilepsy ____Genetic SpinalCondition

___High Blood Pressure ____Heart Problems ____Multiple Sclerosis ____Neurological Problems ____Parkinson's ____Polio

___Prostate Problems ____Stroke/Heart Attack
Other:

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	❑Y	❑N	Loss of loved one	❑Y	❑N	Abuse	❑Y	❑N
Work or school	❑Y	❑N	Divorce/separation	❑Y	❑N	Financial	❑Y	❑N
Lifestyle change	❑Y	❑N	Parents divorce	❑Y	❑N	Illness	❑Y	❑N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.)
The following will reveal exposures you may have had.
Were you **vaccinated?** ❑Y ❑N If yes, did you have a **reaction**? ❑Y ❑N
Have you been **exposed to** any of the following on a regular basis, past or present?
❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑Other
If yes, please explain:_____
Do you have any **food allergies**? ❑Y ❑N **If yes, please list: _____**
_____
How many **fast food meals** do you eat per week? _____
How many **alcoholic beverages** do you drink per week? _____
Do you smoke **tobacco products**? ❑Y ❑N If yes, how many packets per day? _____
How many glasses of **water** do you drink per day? _____
How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____
Are you currently on **prescription** or **over-the counter medication?** ❑Y ❑N Please list, indicating dose & frequency_____
_____
Please list any **nutritional supplements** you are taking: _____
_____
How do you rate your **physical health**? ❑Excellent ❑Good ❑Fair ❑Poor

QUALITY OF LIFE

How do you rate your **emotional/mental health**? ❑Excellent ❑Good ❑Fair ❑Poor
How do you rate your overall **"quality of life"**? ❑Excellent ❑Good ❑Fair ❑Poor

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

_ Relief of a symptom or problem
_ Relief and prevention of a symptom or problem
_ Healthier spine and nerve system
_ Optimal health on all levels

What are your top three health goals?

1. _____
2. _____
3. _____

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ _____ Date: _____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

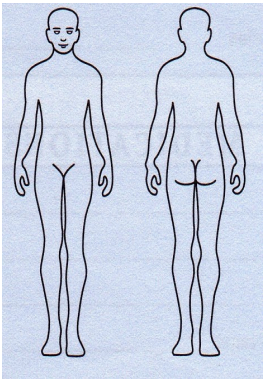
Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

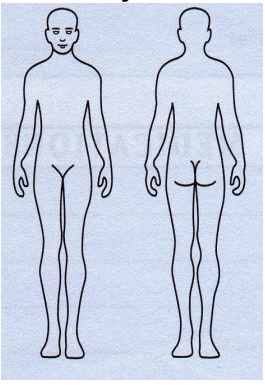
Primary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

Office Use Only:

Secondary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

Office Use Only:

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Office Policies & Procedures

_____**1. Symptoms:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

_____**2. Appointments:** A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours **so you stay on target for wellness**. *It is your responsibility to get here*. We will do all we can to accommodate you.

_____**3. Daily Visit Procedure:** Each time you arrive for your adjustment, check in and have a seat in the reception room until you are directed to go to the adjusting room, place a piece of face paper on the table, lay down on your stomach and relax until the doctor arrives.

_____**4. Progress Examinations:** During your Initial Intensive Care you will receive several examinations to monitor your level of spinal correction. On this visit you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending approximately 15 extra minutes on these days. There is an additional fee for this visit unless you are on a Prepayment Plan that is all inclusive. On your next scheduled appointment following your Progress Examination, the doctor will sit down with you to discuss your results. At the end of your Initial Intensive Care plan, you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

_____**5. Exercise:** Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, discs, and nerves. **However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced.** We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

_____**6. Results:** We are very results-oriented, however many factors that we have no control over may affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

_____**7. Friends and Family:** Part of our mission is to introduce as many people to the far-reaching benefits of Chiropractic. As part of that mission, we are offering any family member or friend to have a spinal evaluation, which includes a health history, thorough examination and x-rays at our expense. There is no other obligation to participate in chiropractic after this introductory offer. The offer is valid within 2 weeks after you start care in our office.

PATIENT: _____ DATE: _____

WITNESS: _____

Congratulations on choosing Chiropractic. Follow through with your family, and enjoy the health benefits that come with a Chiropractic lifestyle.

PRAVO Wellness Centre

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 towards the same objective.

Chiropractic has only one goal: to increase joint and neurophysiological function and eliminate misalignments within the spinal column which interfere with the expression of health. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion of disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which compromises neural integrity and may influence organ system function and general health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of 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 a health care provider who specializes in that area.

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 subluxation.***

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

Signature Date