My Life Story

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 **Innate 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)*:

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

History of Physical Stress, Trauma or Challenges

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

History of Chemical Stress, Trauma or Challenges

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

History of Mental/Emotional Stress, Trauma or Challenges

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

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

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

O water (# of glasses per day ____)	O alcohol	O tea/coffee
O soda	O energy drinks	O juice
O caffeine		

Do you relate any of the experiences checked above to your current state of health? **O**Yes **O**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.)

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

For women:

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

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

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

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

_____

_____

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.*)

_____

_____

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.

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. Mike Moratto'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. Mike Moratto 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_____

NOTICE OF PRIVACY PRACTICES

Appointment Calls, Open Room Adjusting & Health Care Information
Dr. Mike Moratto, and members of the practice staff, may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, you revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.
You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (#164.524)

This notice is effective at time of signing and will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Signature_____ Date_____