If you are tired of feeling “sick and tired” and want to be full of energy and vitality again, we can help you.

Dear New Patient,

Thank you for choosing Essential Healing Chiropractic for your health care needs.

My name is Dr. Robert Ciafone “Dr. Rob” and I am a chiropractor who specializes in Neurological Integration System (NIS). I am looking forward to helping you reach your health care goals. In order for us to get started, you just need to print this paperwork, fill it out, and bring it with you to your first appointment. Please Do Not email the forms back to us. Please take the time to fill them out in as much detail as you can provide. This information is very important to me in helping to determine the best strategy in helping you reach your health goals. **Please arrive 15 minutes before your scheduled appointment time with your paperwork already filled out.** This will allow us to start on time and give you the best possible experience in our office. Please feel free to call us at 770-592-5525 if you have any questions.

We are looking forward to helping you “Get out of Stress with NIS”

Dr. Rob

Office hours:  
Monday closed  
Tuesday, Wednesday, Thursday 8:30am to 7:00pm  
Friday 8:30am to 3:00pm  
Saturday 8:30am to 3:00pm
About You

Name:_________________________________ Date:__________________
Address:_________________________________ Apt#________ City:_______________ St:_____ Zip:________
Home Phone #:________________ Work Phone#:_________________ Cell #:_________________________
E-Mail:________________________________________________________________________________________
Employer:___________________________________ Occupation:_____________________________________
Sex: M F | Marital Status: S M D W | Age:_______ Date of Birth _________/_________/____________
Spouses Name:_____________________ Employer:___________________ Cell Phone#:_______________
Who may we thank for referring you to our office?

Reason for Visit

Reason for today’s visit: __ emergency __ new injury __ old injury __ chronic pain __ wellness
When did your accident occur?_______________ Where did your accident occur?________________________
Please explain what happened_________________________________________________________________________

Did your injury occur during: __ work __ sports/play __ auto accident __ routine/household activity
Are you in pain? __ yes __ no Rate your pain on the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Describe the pain: __ sharp __ stabbing __ throbbing __ burning/searing __ aching __ numb/tingling
Does the pain radiate? __ yes __ no If yes, to where:

Is there anything that makes it feel better? __ rest __ motion __ changing positions __ ice/heat __ meds
Is there anything that makes it feel worse? __ standing __ lying __ sitting __ motion __ rest __ice/heat
Is your condition getting worse? __ yes __ no __ constant __ comes and goes
Is your condition interfering with? __ sleep __ work __ play __family life __ daily routine
Has this or something similar happened in the past? __ yes __ no Explain:________________________________________

Using the adjacent body charts, please circle all affected areas

Have you been treated by any other professionals for this condition? __ yes __ no
If yes, where?

____________________________________________________

____________________________________________________
Please list any surgeries with dates and / or any other serious medical conditions not listed above:
_______________________________________________________________________________________________________

List any past serious accidents with dates:_______________________________________________________________

Date of last physical exam:__________________ Reason:___________________________________________________

Please list any medications or nutritional supplements you are currently taking and why: __________________
_______________________________________________________________________________________________________

Females only:  Are you taking birth control?  __ yes  __ no  Are you pregnant?  __ yes  __ no
Are you nursing?  __ yes  __ no  Hysterectomy?  __ yes  __ no
Patient Questionnaire

Any old injuries that still bother you today? ________________________________________________________________

When was the last time you felt well? ________ Did something trigger your change in health? ________

Please underline or circle any of the following symptoms that you have experienced in the last 30 days

**Head** – Headaches, Migraines, Pressure, Dizziness/Vertigo, Loss of balance?

**Eyes** – Glasses, Contacts, Dry eyes, Irritated eyes, Sore eyes, Burning, Cataracts, Astigmatism, Glaucoma?

**Ears** – Poor hearing, Hearing aids, Ringing, Infections, Itching, Balance problems?

**Nose** – Poor sense of smell, Nosebleeds, Runny nose, Dry nasal passages, Snoring, Sleep apnea?

**Mouth** – Mercury fillings, Implants, Dentures, TMJ dysfunction, Clenching, Grinding the teeth, Braces?

**Nails** – Ridges, Cracks, Brittle, Splitting, Poor growth, White spots?

**Cardiovascular** – Palpitations, Fast Pulse, High or low blood pressure, Shortness of breath, Chest pain?

**Respiratory** – Asthma, Cough, Wheezing, Difficulty breathing, Mucus, Sinus pressure?

**Urinary** – Frequent urination, Loss of control, Burning, Kidney stones, Other?

**Digestion** – Burping, Heartburn, Bloating, Nausea, Vomiting, Diarrhea, Constipation, Gas, Mucus, Blood, Ulcers, IBS, Candida, Gall bladder attacks, Other?

**Endocrine** – Tired in the morning, Tired in the afternoon, Weight gain, Slow metabolism, Hair falling out, Outer third of eyebrow thins, Heart palpitations, Anxiety, Inward trembling, Frequent thirst?

**Males only** – Urination difficulty or dribbling, Frequent urination, Decrease in libido, Decrease in fullness of erections, Episodes of depression, Spells of mental fatigue, Decrease in physical stamina?

**Females only** – Perimenopausal, Menopause, Extended menstrual cycle (over 32 days), Shortened menstrual cycle (under 24 days), Scanty blood flow, Heavy blood flow, Symptoms worse during second half of cycle, Breast pain and swelling during menses, Acne, Facial hair growth, Ovarian cysts, Other?

On average, what time do you go to sleep? ________ Do you have a hard time falling asleep? Yes No

On average, what time do you wake up? ________ Do you have a hard time waking up? Yes No

Do you feel rested in the morning? Yes No Rate your sleep quality Great Good Fair Poor

Do you sleep through the night? Yes No If no, what time(s) do you wake up? ______________

What foods do you crave? ____________________________________________________________

Do you have any food allergies? ________________________________________________________

Do you have any allergies to vitamins, herbs or nutritional supplements? ____________________

**General energy levels?** High Low **Do you feel better in?** The morning The evening

**Stress Level?** High Low **Is your stress related to?** Work Home Finances Other ______________

What do you hope to achieve in your care with us? __________________________________________

Is there anything else you would like to discuss with the doctor? ____________________________________________________________

_________________________________________________________________________________

Consent for examination

• We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

• I authorize the staff to perform any necessary services needed during diagnosis and treatment.

• The statements made on this form and attached forms are accurate to the best of my recollection, and I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature________________________________ Date________________
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. Our only goal is to help your nervous system restore all of the signals to all of your cells. We do not offer to diagnose or treat any disease or condition. However, if during the course of your examination or treatment, 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.

I understand that NIS is considered an elective procedure by insurance companies, therefore I will not be provided an insurance receipt to send to my insurance company including Medicare, nor will I ask my insurance company to be billed for services that are provided by Essential Healing Chiropractic, which have no billable insurance code. I understand that I am solely responsible for all charges for services provided to me by Essential Healing Chiropractic. Upon request, we can provide you with a statement at the end of the year for tax purposes only.

I hereby request and consent to the performance of NIS, chiropractic adjustments, other chiropractic procedures on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor. I further understand and am informed that, as in all health care, there are some slight risks to and do not expect the doctor to be able to anticipate or explain all risks. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read the consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

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 ____________

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 partners have permission to perform an evaluation. Date of last menstrual period: ___________________________ 
________________________ Date ___________________________

(signature)

Missed Appointments:

Our cancellation policy is as follows. We ask that you kindly give us 24 hours notice if you are unable to keep your appointment. This gives us the necessary time to reschedule your appointment and schedule another patient in need of treatment in your place. With the first missed appointment, we will kindly remind you to give us 24 hours notice for future cancellations to avoid being charged a fee. With the second missed appointment, there will be a $25 fee. With the third missed appointment, the fee will be based on the full price of the visit time scheduled. The forth missed appointment will result in termination of care. We are very understanding and know that life throws us unexpected situations, and we will do our best to accommodate you.

________________________ Date ___________________________

(signature)

Financial Policy:

Payment is expected when services are rendered, unless previous arrangements have made. We accept cash, checks, Visa, Discover, MasterCard, American Express and Debit cards. There will be a $25 fee for any returned checks. There is a fee charged for any reports required by any third-party members.

________________________ Date __________________________

(signature)
Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I, ____________________________, hereby consent and state my preference to have my chiropractor, Dr. Robert Ciafone, and other staff at Essential Healing Chiropractic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Appointment reminders are only made if verbally requested by you.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number____________
Email___________________
Text___________________

I give permission to contact me, relative to appointment reminders only, by the following methods:
Phone message at the following number______________
Email messages at the following email address____________________
Text messages at the following phone number_______________