ACTIVE
Chiropractic

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An 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: A 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 diagnose or treat any disease or condition other than vertebral subluxation. However, if 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 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 a major interference to the expression of the body s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

Dr. Brent Reiche

810 Portland Road Saco, ME 04072 www.activechiropractor.com ph) 207-571-8028 fax) 207-284-2034

Active Chiropractic

Better Health Is Closer Than You Think. Brent Reiche, D.C.

810 Portland Rd Saco, ME 04072
TEL 207-571-8028
FAX 207-284-2034

You have ***the right to inspect and/or copy your health information*** for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by the law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your comment to Dr. Brent

If you would like further information about our privacy policies and practices please contact: Dr. Brent.

____
Name (Printed please)

___________________________________ ______________
Signature Date

Active Chiropractic

Be More Active with Chiropractic Brent Reiche, D.C.

810 Portland Rd Saco,ME 04072
TEL 207-571-8028
FAX 207-284-2034

PATIENT AUTHORIZATION FOR APPOINTMENT REMINDERS, SCHEDULING RELATED MATTERS AND SPECIAL EVENTS

It is our desire for our staff to use your name, address, e-mail and or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, appointment related issues, or other special events (birthdays, healthcare classes, functions, etc.)

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information your decision will have no adverse effect on your care from Dr. Brent or on your relationship with our staff.

Your signature indicated your authorization of this activity.

____
Name (printed)

________________________________ ____________
Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow reasonable processing time for the change in our system to be completed.

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The Chiropractic Office of Active Chiropractic

Patient authorization for contact regarding chiropractic care, related health services/or related health products

It is our desire for our staff to use your name, address, e-mail and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office efficient, productive and to further enhance your access to quality health care.

If you choose not to authorize this information your decision will have no adverse effect on your care from Dr. Brent or on your relationship with our staff.

Your signature indicates your authorization of this activity.

____
Name (printed)

_______________________________ __________
Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable time for the change in our system to be completed.

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Patient Authorization regarding chiropractic care being provided in an open adjusting environment

It is the practice of this office to provide chiropractic care in an open adjusting environment. Open adjusting involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an incidental disclosures of health information. It is our view that the kinds of mailers related in an open adjusting environment are incidental mailers, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the doctors or on your relationship with our staff.

Your signature indicates your authorization of this activity.

____
Name (printed)

_____________________________ ___________
Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Consequences of neglecting subluxations
vs.
Benefits of correcting subluxations

Consequences (includes, but not limited to…)

- Reduced Range of Motion
- Make you look and feel old before your time.
- Declining Immune function.
- Alter and interfere with internal organ function.
- Cause acute and chronic pain.
- Cause weakness and numbness.
- Cause loss of energy and fatigue.
- Reduce ability to cope with stress.
- Progressive bone deformation, ligament damage, scar tissue and disc decay.
- Cause loss of height with age.
- Diminish athletic performance.
- Lead to physical and mental disability.
- Cause Spinal Canal narrowing.
- Diminish the quality and length of your life.

Benefits (includes, but not limited to…)

- Increased range of motion and flexibility
- Keep you and your joints young.
- Prevent, reduce or eliminate pain, symptoms.
- Prevent, reduce or eliminate the need for most medications.
- Increased immune function.
- Increase athletic performance, energy and stamina.
- Increased ability to handle stress.
- Prevent, reverse or control spinal decay.
- Optimize focus, concentration, memory and mental ability.
- Permit normal internal organ function.
- Help balance hormones and mood swings and depression.
- Improve and make breathing easier.
- Better digestion.
- Better sleep.
- Increased general sense of well-being.
- Increase the quality and length of your life.
- Optimize nerve function and therefore your *whole life*.

Active Chiropractic, 810 US Route 1 Saco, ME 04072
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Personal Information

Name ____________________ Address ____________________ City ____________________ Zip _______

Day Phone ____________________ Social Security # ____________________ E-mail Address ____________________

Evening Phone ____________________ Employer ____________________ Referred By ____________________

Birth Date ______________ Age ______ Sex _____ Emergency Contact, Name & # ____________________

Circle One: Married / Single / Widowed / Divorced / Separated Spouse's name ____________________

Health Insurance ____________________ Name & Birth Date of Insured ____________________

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure	Comments (if any)
Did you have any childhood illnesses?	☐	☐	☐	____________
Were you vaccinated?	☐	☐	☐	____________
Did you have any falls from a height over 3 feet? (i.e. crib, bunk bed, trees)	☐	☐	☐	____________
Did you play youth sports?	☐	☐	☐	____________
Did you take/use any drugs?	☐	☐	☐	____________
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	____________
Were you involved in any car accidents?	☐	☐	☐	____________
Did you suffer any form of abuse?	☐	☐	☐	____________
Were you under regular chiropractic care?	☐	☐	☐	____________
Adulthood - (18 to present)				
Do / did you smoke?	☐	☐	☐	____________
Do / did you drink alcohol?	☐	☐	☐	____________
Have you been in any accidents?	☐	☐	☐	____________
Do / did you play adult / extreme sports?	☐	☐	☐	____________

On a scale of 1-10 describe your level of stress (1 = none / 10 = extreme) Occupational _______ Personal _______

Which answer best describes your own current ideas and values toward health?

☐ TREATMENT ONLY - I only consult a doctor when I have a problem/symptoms and discontinue as soon as the symptoms leave.
☐ EARLY DETECTION - In addition to symptom relief, I see dr.'s occasionally to detect problems early before they become serious.
☐ PREVENTION - I'm conscious about my health, diet, exercise and actively pursue these because I feel & perform better.
☐ WELLNESS - I actively inform myself about true health and I am concerned with the long-term effects of things on my health.

Have you ever:

Bought bottled water: ☐ Yes ☐ No
Joined a health club: ☐ Yes ☐ No
Consumed vitamins or supplements ☐ Yes ☐ No

To help us better explain chiropractic as it applies to your health and life and how we may be able to help you, please check the one best answer for each statement below:

1) I remember important things in my life by what I … ☐ see ☐ hear ☐ feel
2) The primary reason I brush my teeth is to … ☐ avoid tooth decay and gum disease ☐ make sure I have healthy teeth and gums
3) When I make decisions I generally... ☐ gather the facts and weigh the evidence ☐ make the right choice instantly ☐ consult my friends and family ☐ depends on how I feel about it

Each of us must balance a variety of demands on our time, money and emotions. Please rate the following items, in order, relative to their importance to you with a (1) being the most important and (7) being the least important.

_____ Marriage _____ Automobile _____ Job _____ Health _____ House _____ Kids _____ Pet

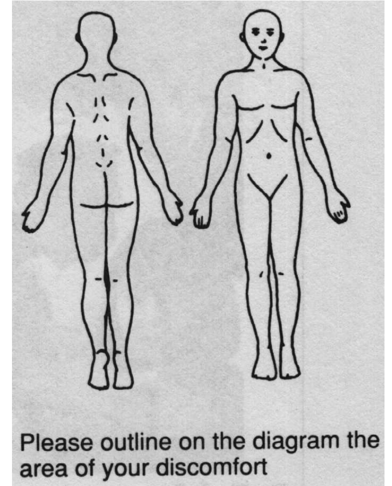
Addressing the Issues that Brought you to the Office

Briefly describe your main concern. *If you're here for wellness care please go to #11* ____________________

1) If you are experiencing a symptom, is it… (check more than one if necessary to describe your problem)

☐ Sharp ☐ Dull ☐ Burning ☐ Numbness & Tingling ☐ Pressure ☐ Comes and Goes ☐ Travels ☐ Constant

2) Where is the symptom? ____________________



3) When did the *symptom* first start? ____________________

4) Since the symptom started, it is…

☐ About the same ☐ Getting Better ☐ Getting Worse

5) What makes it worse: ____________________

6) Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

8) Does this cause you to be: ☐ Irritable ☐ Moody ☐ Worried

9) Is your Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury

10)Other Doctors seen for this problem and when (please list).

☐ Chiropractor ____________ ☐ Medical Doctor ____________ Other ____________

11) Drugs you now take: ☐ Over-The-Counter Pain Relievers ☐ Prescription Pain Medications ☐ Muscle Relaxer ☐ Blood Pressure Medicine ☐ Insulin ☐ Other ____________ ☐ None

12) Past Surgeries/ Operations ____________________

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
☐ **Sinus Problems**	☐ **Allergies**	☐ **Asthma**	

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children ____________________

Spouse ____________________

Mother/Father____________________

Siblings ____________________

Others ____________________

FEMALE ONLY: Is there any chance that you may be pregnant? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate care, any fees for services rendered to me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of, but not limited to, spinal adjustments. It is understood and agreed the amount paid the doctor is for the examination and reading of x-rays only. The x-rays will remain property of this office, being on file where they may be seen at any time while a client of this office. The client also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Client's Signature ____________________ Date ____________