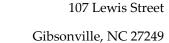
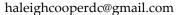




Participant Health Profile Welcome to Community Chiropractic! Please fill out everything on this form, even if you feel it does not apply to the reason you are coming in for care. Thank you for choosing us as part of your healthcare team.

| Who referred you to our office? | May we thank them? Yes No | |
|---|--|--|
| General Information: | | |
| Name: | What do you like to be called? | |
| Gender: M / F / Other Date of Birth: | Age: Height: | |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | |
| E-Mail: | | |
| T | | |
| Emergency contact: | | |
| NamePhone: | Relation: | |
| (Rate your family's health by writing a number by excellent health) | their name below using the scale: $0 = poor health * 10 =$ | |
| Married/Life Partner? Yes No Significant C | Other's Name: | |
| Children's Name(s) and Age(s): | | |
| Occupation: | Employer: | |
| Do you enjoy what you do? Y / N Explain: | | |
| Duties/ Habits: sit more than 1 hour carry | y equipment/tools on your body (i.e. utility belt, child) | |
| repetitively bend or twist cradle the phone show | ulder to ear (which side? L or R) repetitively type | |
| drive on the job (car or other) lift more than 10 lbs repetitively | | |





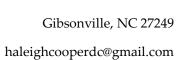


About Your Health

The human body is designed to be healthy. Throughout life events occur and our body has two options: It can either integrate experiences or store them to be integrated at a later time when the body is better capable. These stored experiences eventually become symptoms in the body, thus giving us a lesser quality of life. This case history will uncover the layers of stored experiences in your body. Following the exam, you will get an outline of care that will begin to correct and release these layers and recover your innate health potential.

| Provider's Name | Provider Type | Last Visit | Reason | Result |
|--|--|-------------------|-------------------------|-----------------------------------|
| | | | | |
| Current Health Cond | cerns (Please follow instr | | • | er all health concerns verbally.) |
| | | | | |
| When/how did this c What activities aggra What activities allevi | tant to you and why? oncern first begin? vate your concern? ate your concern? e during certain times of th | | | |
| Does it affect your | workrelationship | ps or intimacy | decision m | akingexercise or play |
| | attitude, mood, patience | eability to | relax or sleep | day-to-day activities |
| Do you havepai | nnumbnesstingli | ngaches | | |
| Is your painshar | rpdullthrobbing | constant _ | _intermittent | |
| Do you feelswel | lingcrampingstif | fnessburni | ng | |
| Do you have any oth | er health concerns? | | | |
| Your Mom's Pregnan | ncy with You/ Your Birth: | (check all that a | ipply) | |
| Tobacco Falls/injuries | Alcohol Abuse (any typ | | Medications Hospital | Recreational drugs Home |
| Vaginal | Cesarean | V | acuum | Forceps |
| Medications | Epidural | | Complications | |







| Childhood (Age 0-18): (checl | c all that apply) | | |
|--------------------------------|---|---|-------------|
| Breast fed | Formula fed (Dairy or soy?) | Abuse (any type) | Surgeries |
| Accidents/falls/injuries | Dislocations/fractures | Scoliosis | |
| Orthodontics (braces, etc.) | Nightmares/night terrors | Played in a hanging/ bo | ouncy swing |
| Crawled before walking | Special dietVaccinat | ionsMedications | |
| Allergies/Eczema | AsthmaEar infe | etions | |
| Current Health/Stress | | | |
| Diet: (Unhealthy = 0 ⊚ Extreme | ely Healthy = 10) Your score? | Details: | |
| Special Diet?Gluten free | PaleoVegetarianV | egan Other: | |
| Food sensitivities: | Food All e, what for, and who recommend | ergies: | |
| vitainins of supplements. typ | e, what for, and who recommend | eu: | |
| Medications: type and for wha | nt? | | |
| Exercise: Frequency/ type: | | | |
| | day): | | |
| How much do you consume J | per day of the following? | | |
| | Decaf coffee: | | _ |
| | Decaf tea: | with cream? Y N Wit Regular or diet? (circle o | |
| Caffeinated soda: | | - | |
| | Juice: | | |
| Tobacco: | Alcohol: | Type: | |
| put a "10") | n on a scale of: 0 = worst @ 10 = b Mental/emotional stressP | est (i.e. If you love your job & | |





| Adult History (Age 19 to present): | Mark all that apply with (N) for Now | , (P) for Past | |
|--|--------------------------------------|-------------------------------|--|
| Weight Changes | Frequent Colds/Flu | Asthma/Respiratory Disease | |
| Sinus/Allergies | Skin Conditions | Anemia | |
| Neck/Back pain | Numbness/Tingling | Arthritis (Type:) | |
| High Cholesterol | Stroke | High Blood Pressure | |
| Concussion/Head Injury | Digestive Issues | Urinary Tract Issues | |
| Bowel/Bladder Issues | Menstrual Issues/Pain | Reproductive System Disorders | |
| Menopause | Thyroid Disorder | Prostate Issues | |
| Ears/Hearing Issues | Eyes/Vision Issues | Dental/Jaw Issues | |
| Cancer | Depression | OCD | |
| Bipolar Disorder | Autism Spectrum Disorder | Pregnancies | |
| Surgeries | Injuries/Accidents | Dislocations/Fractures | |
| Abuse (Any type) | Tobacco | Alcohol | |
| Recreational Drugs | Vaccinations | Chronic Fatigue | |
| | | | |
| Chiropractic History | | | |
| Have you been to a chiropractor bef | fore? Yes No | | |
| How old were you the first time you were adjusted? | | | |
| Who was your most recent chiropractor? | | | |
| When was your last adjustment? Reason for visit: | | | |
| Result: | | | |
| Describe techniques used: | | | |
| In your own words, what do chiropractors do? | | | |
| | | | |



| , | ctic care? |
|--|---|
| | and you, your history, or your needs which has not been |
| | |
| | |
| *** Domamhar hoolth is a presses. Doct and presses | at the ciaco offect this process. Then I way for taking the time of |
| provide us with the information we need to best h | nt choices affect this process. Thank you for taking the time to the selp you achieve your health goals. Congratulations on a for giving us the opportunity to participate in this process. |
| Signature: | Date: |
| Chiropractor Name: | Date: |
| Chiropractor Signature: | |

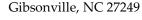


FEMALS ONLY

History on Past and Current Pregnancies and Births

(Include if you have ever been pregnant)

| Are you currently pregnant? Yes / No |
|--|
| How many weeks are you? Guess Date: |
| Do you plan on birthing at:HomeBirthing CenterHospital |
| If not birthing at home, please name birthing location: |
| Do you plan on using a: (check all that apply)DoulaMidwifeNurse MidwifeOB Names: |
| Do you plan on breastfeeding? (Please answer assuming there are no unexpected issues.) |
| Yes: For how long and why? |
| No: Why not? |
| Do you plan on vaccinating this child? Yes No |
| If yes, what type of schedule are you choosing:CDC FullDelayed FullModified |
| Why? |
| Have you done your own research on vaccinations? |
| Have you ever had an abortion? Yes No Complications? |
| Have you ever had a miscarriage? Yes No Complications? |
| Past Deliveries: How many? |
| *Please answer the following questions regarding your most recent birth. |
| Third Trimester Presentation:Vertex (head down)BreechTransverseFace/Brow |
| Posterior Type of Birth:VaginalForcepsVacuumCesarean (ER or planned?) |
| Interventions:MedicationEpiduralRuptured MembranesEpisiotomyAssisted |
| Pushing |
| Delivery Location: |
| OB/Midwife Name: |





Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, subtle energy rebalancing and supportive therapies on me (or on the person named below for whom I am legally responsible) by Haleigh Cooper, DC at Community First Chiropractic.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, sprains, fractures, disc injury, stroke and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions and ultimately improve health. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands upon my body to adjust joints and release muscles, which may cause an audible "click" or "pop" during the procedure.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not quaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for adjustment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and can secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

| Name (Printed) | Date Signed | |
|--|--------------------------------|--|
| Signature: Patient or Legal Representative Guardian, Parent) | Witness to Patient's Signature | |



Terms of Acceptance / Philosophical Agreement

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

- There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
- The Nerve System is the main coordinating and distribution system for the body's innate intelligence. 0
- Alterations or distortion in the shape, position, tone, or tension of the Nerve System (especially at the spine) will interfere with the expression of this intelligence.
- Chiropractors call this interference to the proper functioning of the Nerve System a Vertebral Subluxation. Subluxation causes alternation in nerve function and distorts the communication channels between the brain and the body. The result is a lessoning of the body's ability to express its maximum health potential.
- Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.
- An Adjustment is the specific and honoring application of forces to facilitate the body's release and integration of subluxation.
- The sole purpose of the chiropractic adjustment in this office is to assist your body to release vertebral subluxation and benefit from the restoration of clear communication channels in the body. Everyone, regardless of their age, symptoms or ailments, will benefit from a nerve system which is more flexible, elastic, and free of vertebral subluxation.
- Chiropractic is not a substitute, an alternative or a preventative form of medicine. We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body's innate wisdom and to support your body to hold and integrate adjustments and healing. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.

| I, pertaining to my care in this office. I acc | , have read the above statements and understand the doctor's obj | ectives |
|---|--|---------|
| Signature | Date | |
| Consent to evaluate and adjust a r | minor/child: | |
| | ing the parent or legal guardian of ms and acceptance and hereby grant permission for my child to receive | _ have |





Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

- 1. Community First Chiropractic's (CFC) Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for CFC to provide treatment to me, and necessary for CFC to obtain payment for that treatment and to carry out its health care operations. CFC explained to me that the Privacy Notice will be available to me in the future at my request. CFC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.
- 2. CFC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law and I will be informed of any revisions.
- 3. I understand that, and consent to, the following communications that will be used by CFC: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me. [Please note: email and text messages are not secure, protected forms of communication. By signing below you are acknowledging your choice to use them to communicate PHI.]
- 4. CFC may use and/or disclose my PHI in order for CFC to treat me and obtain payment for that treatment, and as necessary for CFC to conduct its specific health care operations.
- 5. I understand that I have a right to request that CFC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, CFC is not required to agree to any restrictions that I have requested. If CFC agrees to requested restrictions, then the restriction is binding on CFC.
- 6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the CFC has already taken action in the reliance on this consent.
- 7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice. CFC will not treat me. I further understand that if I revoke this consent, at any time, CFC has the right to refuse to treat me.
- 8. CFC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in CFC's practice.
- 9. Visits and spinal adjustments are performed 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. If you have comments or information you wish to share privately when you come into the adjustment room please inform the doctor or staff and we will accommodate your needs.

I acknowledge that I have received a copy of CFC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer, Haleigh Cooper. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

| Patients 's Name (printed) | Date Signed |
|---|-------------|
| | |
| Signature (patient or legal representative) | |



RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Community First Chiropractic. The written notice must contain the following information: your name and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Community First Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Community First Chiropractic will not refuse to provide treatment however, it will not be possible for Community Chiropractic to contact me to schedule appointments or discuss my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.