

CLEARVIEW CHIROPRACTIC LIFE CENTER, P.A.

SHARLA B. ROBERTSON, D.C.

5417 ACTON HWY. SUITE 101

GRANBURY, TEXAS 76049

(817)326-1174

HEALTH RESUME

Name _____ Age _____ Date of Birth ____ - ____ - ____

Address _____
Street or PO Box City State Zip

Phone(Home) _____ (Work) _____ (Cell) _____

E-Mail Address _____ Occupation: _____

Sex: M F Marital Status: Single Married Widowed Div.

Spouse's Name _____ Spouse's Occupation: _____

How many children? _____

Names & Ages of Children _____

How did you find out about Clearview Chiropractic and/or Dr. Sharla?

Please describe what type of activities you do daily:

WORK: _____

HOME/LEISURE: _____

Have you ever consulted a Doctor of Chiropractic? _____

If yes, who? _____

When was your last visit? _____ How long were you under care? _____

Did you receive X-rays? Yes No If yes, when were they taken? _____

Please describe what concern brought you here today _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered:

X _____
Signature Date

Privacy Act:

I consent to the use of my protected health information by Dr. Robertson for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance.

X _____
Signature of Patient Printed Name of Patient Date

PLEASE MARK the conditions you have now or in the Past 6 months:

Joint Pain Cancer Diabetes Depression Anxiety Low Self Esteem
 Arthritis High Blood Pressure High Cholesterol Heart Disease
 Low Energy Numbness, Where? _____ Tingling, Where? _____
 Acid Reflux Hearing Problems Trouble Sleeping Diarrhea
 Constipation Low Self Esteem Osteoporosis ADD / ADHD
 Decreased Productivity Decreased Enjoyment of Life & Daily Activities

Please list any other health concerns you have at this time: _____

What is your biggest concern about your Life/Health/Body? _____

What's the BEST benefit you'll experience when you become Healthier? _____

Right now, are you as Happy & Healthy as you want to be? YES NO

Physical Stressors:

Any Accidents or Injuries: _____

Childhood Injuries: _____

Broken Bones: _____

Surgeries w/ Dates: _____

Any Other Medical Procedures: _____

Do you do any physical activity? Y N If yes, what type? _____ How often? _____

Chemical Stressors:

List any and all Prescription Drugs & the conditions you take them for: _____

List any and all over-the-counter medications: _____

List any and all Supplements: _____

Do you smoke or chew tobacco? _____ How Much? _____

Do you drink alcohol, how often? _____

Do you drink diet sodas or eat sugar-free foods? _____

Do you consume dairy products? Y N Do you eat Wheat/Flour Products? Y N

Do you eat desserts or drinks with sugar? Y N How many glasses of Water daily? _____

Do you eat fresh or frozen vegetables or fruits daily? Y N

Emotional Stressors:

Do you feel loved & appreciated enough? Y N Do you have stress at work? Y N

Do you have stress at home? Y N Do you worry about something daily? Y N

Sleep Patterns:

How long does it take you to fall asleep? _____ What position do you sleep in? _____

Do you wake up frequently? Y N Why? _____

How many hours of sleep do you usually get? _____

Do you feel Well-Rested when you wake up? Always Sometimes Never

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

HEALTH: The 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 the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments 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 the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

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

All questions regarding the doctor's 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)

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.

For all Female Patients of Child-Bearing capability:

Pregnancy Release

This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Robertson has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

(signature)

(date)

What aspects of Wellness do you want for yourself? (please check as many as you'd like)

- | | | |
|--|---|---|
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Better Sleep | <input type="checkbox"/> Freedom from pain |
| <input type="checkbox"/> Better Concentration | <input type="checkbox"/> Enhanced emotional Well-being | <input type="checkbox"/> Reduce/Eliminate Medication use |
| <input type="checkbox"/> Improved Digestion | <input type="checkbox"/> Improved strength And endurance | <input type="checkbox"/> Greater resistance to Disease |
| <input type="checkbox"/> Easier breathing, Deeper breaths | <input type="checkbox"/> Better sports performance | <input type="checkbox"/> Better reaction time/reflexes |
| <input type="checkbox"/> Better Balance | <input type="checkbox"/> Improved Posture | <input type="checkbox"/> Overall Health Improvement |
| <input type="checkbox"/> Increased zest for Living | | |

Wellness goals for your family: _____

WHAT TO EXPECT AT OUR OFFICE

This sheet explains our new patient procedures. Please read this carefully so you will know what to expect during your first 2 visits. Thank you for your cooperation...We look forward to sharing Chiropractic and How to Get Well & Stay Well with you and your family!

Today: Consultation & Exam

- Today's visit should take approximately 40 minutes
- Personal Consultation with Dr. Sharla regarding your health concerns
- Complete Biomechanical Exam to determine if Chiropractic care is appropriate for you
- If testing indicates that you may have a serious condition called Subluxation, X-Rays are often necessary
- Comprehensive health history to fully understand your current condition as well as to discover hidden events or lifestyle choices that may have cumulatively impacted your health
- All fees will be discussed with you in advance. We require payment for today's services at the end of the appointment
- At checkout, you will need to schedule your Report of Findings

Day 2: Report of Findings & Dr. Sharla's Best Recommendations

- A specific description of the condition of your spine and nervous system and how these findings impact your current and future health
 - The beginning portion of this report may be in a group setting, so please arrive on time. **All of your personal information is discussed in private with Dr. Sharla.** The reports will begin promptly and cannot be interrupted once they begin
 - Dr. Sharla's report details the solutions available to maximally correct your problem If Subluxation is confirmed, your first adjustment will be recommended on this visit
 - This report is scheduled on very specific days & times
 - This visit should take approximately 45 minutes-1 hour
 - A financial decision regarding your care will need to be made at this time
 - **Please bring your spouse/significant other.** It is critical to the success of your case that your spouse/significant other sees and understands this information so they are able to support you through this process. (A work excuse can be provided if needed for you or your spouse/significant other). Please let us know in advance if your spouse cannot attend, we will need to reschedule you both for the next available report.
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I have read and understand the above information.

Signed: _____