Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name ________________________________

Financial Arrangements

***Please initial ALL highlighted areas**

We strongly feel that our patients deserve the best possible health care that we can provide. Part of this care is a comfortable relationship between our finance dept. and you, the patient. We have found that to avoid future misunderstandings over insurance issues and paying for the services you receive while in our office **this information page is very important for you to read and fully understand**. If you are unclear on something please ask us to explain it so that you and the doctor can stay lifelong associates and maintain a great Doctor-Patient Relationship.

Payment: **We accept cash, checks, and all major credit cards.**
Payment is due when services are rendered. **Initial here:__________**.

Diagnostic Services: ON YOUR FIRST VISIT WE WILL PERFORM INDICATED CHIRORPACTIC DIAGNOSTICS BUT MAY NOT ALWAYS TREAT ON THE FIRST DAY. X-rays may or may not be needed that will be determined by the doctor. If x-rays are indicated your will be referred to a local x-ray facility as we do not take x-rays on site here.

Additional Fees: Returned check charge on any check we get back from your bank is $50.00.
Balances owed longer than 30 days will automatically be charged a finance fee of 29.99%/annum. _______I agree.

FEES: First Day Basic Fees, Exam and Consultation = $285.00 due at time of service. Additional services may be indicated so costs could be higher. This depends on your problems and the testing needed to properly evaluate them.

After your consultation with the doctor he will be able to determine if he can help you and what diagnostic testing will be necessary to move forward with your care. It is impossible for the doctor to render ANY care without testing being done to find out what the problem is and what type of care will be needed to properly help you. After your initial visit you and your "significant other" will be given a full report of what can be done to help you provided the doctor can accept you as a patient. If we can accept you as a patient then you will be given an initial care plan and all financial arrangements will be discussed at this time. We do an extremely detailed, high-tech patient workup to give you and your family the best evaluation possible. The chiropractic adjustment is so beneficial and life-changing when used properly that the more precise we can be with your first visit the better results you can expect.

Chiropractic Health Insurance Coverage: initial here:_______________

We only accept **Anthem Blue Cross/Shield** and **Medicare and Medicare Secondary Ins.** that covers chiropractic care. ***We DO NOT ACCEPT ANY OTHER HEALTH INSURANCE***, you are welcome to file it yourself for reimbursement directly to you. We do this in an effort to keep healthcare costs affordable and since our regular office visit fee is what most copays are, so accepting or not accepting insurance doesn't really matter. You will find that you will pay the same or less here in our office for your chiropractic care as compared to any other local chiropractic office. We cannot guarantee that your insurance will cover all or any of your services received here in our office and take no responsibility for reimbursements. You are responsible for all charges in full that are incurred at this office.

Print Your Name ________________________________

Contact Information. ALL LINES MUST BE FILLED IN COMPLETELY OR WE CANNOT TREAT YOU

If minor Name of Legal Guardian_______________________

If married spouse's name _______________________________ Children: Yes : How many _________

Address ________________________________City _____________________State _____Zip______

Cell Phone ____________________ Home Phone __________________ Work Phone ____________

Patient Email____

Date of Birth ____________ Patient's Marital Status: Single Married Separated Divorced Widowed

Social security # _________________________________

Who referred you to our office? ______________________

Employer/School attending if student _____________________________________

Employer/school address ____

What kind of daily activities do you do at work and/or home? (**Please circle:** standing for more than 1 hour, driving more than an hour at a time, loading/unloading vehicles, stockyard or warehouse work, drive heavy machinery, frequent bending, landscaping, farm work(what type________________________), child care, housework, use laptop/tablet on the sofa/chair regularly, desk work, riding lawn mower/tractor, yard work, use computer at work for more than an hour at a time, other _______________________________________.

Please describe your average day ____

____

____

**We have PRE-PAYMENT plans for cost savings so please ask about them.

How will you be paying for today's charges? Cash Check Major Credit Card

Name of nearest living relative not living with you ____________________________relation? ___________

phone # ______________________ (this is for emergency contact purposes)

Print Your Name ________________________________

Financial Agreement

1. I accept the financial responsibility for the above noted patient at the office of Dr. Demetrios Kydonieus, Life Enhancing Wellness Centers, LLC and based on all statements made in this contract I understand and agree that regardless of insurance coverage I am personally and fully responsible for all charges billed by this office. I understand that Medicare and my insurance may deny coverage at some point and that I have been told this in advance and agree to all outstanding balances in full at the regular office rates for all unpaid services.

2. I give my permission for my credit card to be kept on file to be billed in full for the total outstanding balance to settle my account at this office at any time after my 90 day notice has been sent without any additional notification other than this document at this time. I may revoke this permission in writing at any time in the future with 30 days' notice. My signature on this document is my approval for such billings by this office to me and they cannot and will not be disputed.

3. I understand if I have an unpaid balance to Life Enhancing Wellness Centers, LLC (Demetrios Kydonieus) and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account and possibly including reasonable attorney's fees if so incurred during collection efforts.

4. In order for Life Enhancing wellness Centers, LLC or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that Life Enhancing Wellness Centers, LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

5. By signing below I further understand that if collection proceedings or referral to an outside collection agency are necessary to collect on any balance that remains unpaid for 90 days or longer that I have received notification of, that I agree to pay the an additional collection fee of $300. If my collection case goes to court another $300.00 fee per court appearance and any and all collection/court costs will be added to my final bill if the judge rules in favor of such a collection action. Such fees will be considered additional "healthcare costs".

6. I also understand that I may receive a 1099 for all balances that are "written off" by the office as uncollectible which will be reported to the IRS as additional income.

7. US mail service to the address I have given on page 2 shall be sufficient notice of any and all legal actions. To avoid these additional fees I can pay ALL my outstanding charges on the itemized statement I received in the mail from this office within 10 days from receipt of such a notification before any such collection action has begun. I also understand if a collection matter goes to court I may have 'other' fees such as but not limited to; investigation, travel, and legal/attorney fees of the Plaintiff that I will be responsible for **in addition** to the collection fees noted above. This contract is governed by the laws of Virginia. I knowingly accept all stated terms of financial responsibility noted in this contract and have willfully sought Dr. Kydonieus' time/advice/treatment for my complaints (or the complaints of my child).

I certify that the information I have given is true and correct to the best of my knowledge.

________________________________ ________________________________ ____________

Signature of person responsible for the account **Print Name** Date

Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name _________________________________

Terms of Acceptance and Informed Consent

When a patient seeks chiropractic care and we accept them as a patient for such care, it is essential for both of us 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 that goal. WE ONLY TREAT SUBLUXATIONS in this clinic, if we encounter any condition outside a chiropractic one we will advise you of our findings and may recommend that you seek care outside our clinic for such a condition but that decision is up to you. We do not advise any patient to discontinue medicines but may offer alternatives that a patient may consider and choose on their own if they so desire. We advise all patients to speak with a medical professional when discontinuing meds or any kind but understand that many people may make such a decision on their own without medical advice and we cannot be held responsible for any complications of such individual decisions.

HEALTH: A state of optimal physical, mental, and emotional (spiritual) well-being. When fully attained it keeps all living things in balance and vigorous! This is not just the absence of symptoms (pain, swelling, stiffness, cough, fever, etc.) since symptoms are the last stage of most dis-ease conditions. Problems start long before we are consciously aware of them.

DIS-EASE: A state of well being that is less than healthy. Symptoms may or may not be present to be unhealthy.

SUBLUXATION/ FIXATION: A misalignment of an osseous articulation of the body causing abnormal physical and one or more of the following; abnormal neurological, chemical, and/or mental dysfunction that causes the body to malfunction.

VERTEBRAL SUBLUXATION: A misalignment of one of the 24 moveable bones of the spine called, vertebrae that negatively affects your nervous system and overall degrades your wellbeing and therefor your health.

ADJUSTMENT: The specific application of an outside force to facilitate the body's correction of the subluxation, relieving structural interference that is having an abnormal effect on the body. We use the Activator Instrument and hands-on chiropractic techniques to render our adjustments. All adjustments are considered safe for individuals of all ages. The incidence of stroke from manual cervical adjustments is very slight with certain high risk individuals but if you are concerned ask the doctor to use only the adjusting Instrument which at this time has no history of causing stroke in any individuals noted in the current medical literature.

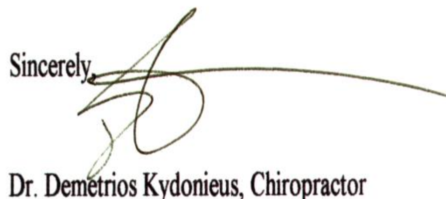
CHIROPRACTIC: The science that deals with the knowledge and art of healing the body by relieving the subluxation complex thus allowing the body to heal itself and return to its optimum state of health without the aid of outside substances or invasive procedures. When the musculoskeletal system is properly aligned the body will function at its highest state of health based on it's overall integrity and physical condition. Physical therapy(PT) is NOT Chiropractic but may be used in addition to chiropractic adjustments in this clinic as indicated by the doctor for speedy inflammation/pain-relief but PT does not correct subluxations. PT is for muscles and other soft tissues only.

"Health comes from within not from a bottle..." BJ Palmer

. I, (print name)______________________________ have read and fully understand the above statement. All questions regarding the doctor's care have been answered at this time to my complete satisfaction and I agree to the proposed and ongoing CHIROPRACTIC CARE at this clinic on this basis.

____
(Patient or Guardian's Signature) (Date)

____
(Patient's Signature) (Date)



Consent to evaluate and treat a minor child: I understand the above statement and being the legal guardian, parent for ______________________________ give my permission for my child to receive chiropractic care now and in the future at this clinic.
(minor child's printed name)

____ I may revoke such consent in the future but I must do so in writing if I so
(Parent/Guardian's Signature) (Date)

Print Your Name ______________________________

Combined Acknowledgement and Consent (HIPPA)

Acknowledgement or receipt of Notice and Consent to use and disclose health information

Read before signing

This acknowledgement of notice and consent authorizes ***DC on Wheels., LLC*** to use and disclose health information about you for treatment, payment and healthcare operation purposes.

Notice of Privacy Practices. a "Notice of Privacy Practices" Brochure that describes how we may disclose your private information and use it is available upon request. It further describes how you can access your protected health information and exercise other rights concerning you and your protected information. You may ask to see and have this information at any time and review it prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any changes effective for all protected health information that we maintain including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer at any time.

How to Contact our Privacy Officer:

Office Manager (Robin Kydonieus)
8881 Seminole Trail
Ruckersville, Virginia 22968
434-481-2012

I have received the Notice of Privacy Practices for this office and authorize them to use and disclose health information for treatment, payment and healthcare operations consistent with this Notice of Privacy about:

Friend us or become a fan of the office page. www.FaceBook.com/DrDSays
Twitter, what is your Twitter ID ____________________can we follow you? YES NO

Can we private message you on Facebook for apt reminders?	**YES**	**NO**
Can we post photos of you from our office lobby on our Facebook page?	YES	NO
Can we email you appointment reminders and visit/test reports?	YES	NO
Home/cell phone: May we leave a message on your answering service?	YES	NO
Work Phone; May we leave general messages at work for you?	YES	NO
Postcards; may we mail announcement or birthday cards to you?	YES	NO

If you give us a testimonial in any form; written, recorded video or audio by signing this HIPPA statement you are giving us your permission to use it on the internet, social media or advertising of any kind without compensation to you in any form. You can revoke this permission at any time but it must be written, signed via certified letter or personally delivered by you and no one else to this office during regular business hours.
(*Email, text, phone call or private message is not acceptable to revoke this clause of this agreement,. It must be in a written, signed letter.*)

____
(Print patient's name)

______________________________ ______________
Patient or patient's representative signature Date

______________________________ ______________
Personal Representative Printed Name relation to patient

Print Your Name ________________________________

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Email address: _________________________@_______________________

DOB: ___/___/______ **Gender (Circle one):** Male / Female **Preferred Language:** _____________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _________________ **Quit Date** ________________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American

White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	First Time noticed(Date)	Additional Comments

Patient Signature: ____Date: _______________

Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name ________________________________

Confidential Patient Health Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:__________

Date of Birth:_____________ age now______

City:_____________________________ **State**:_________ **Zip**:___________
Home Phone: ________________________ **Work Phone**: _____________ **Cell:** _________________
Social Security #(legally required for medical records): ________________________ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated **# of children** ______________
Name of Spouse or Nearest Relative: __________________________ **Cell Phone**: _____________
Your Occupation _____________________________ **Your Employer**: _______________________
Do you currently smoke or vape? YES NO Quit Date ______________________
Referred to this Office by: ❑Friend/Family Member - **Name?** ______________________________
❑ Internet ❑ Mail ❑Clinic Location ❑Other______________________
If auto related Name of Auto Ins.:________________________
If you have what is your Medicare #: ______________________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by you and your family in the past, noted by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	**anemia**	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	**gout**	❑	❑	❑	numbness
❑	❑	❑	**asthma**	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	**heart trouble**	❑	❑	❑	poor circulation
❑	❑	❑	**bladder trouble**	❑	❑	❑	reproductive disorders	❑	❑	❑	**hepatitis**
❑	❑	❑	bone fracture	❑	❑	❑	**high blood pressure**	❑	❑	❑	rheumatic fever
❑	❑	❑	**cancer**	❑	❑	❑	HIV/ARC	❑	❑	❑	**rheumatoid arth**
❑	❑	❑	chest pain	❑	❑	❑	**kidney disorder**	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	**bowel trouble**	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	**diabetes**	❑	❑	❑	**multiple sclerosis**	❑	❑	❑	**thyroid Disease**
❑	❑	❑	**indigestion**	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Other ____

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Personal medical doctor Name_____________________________ Phone #____________________
Permission to contact them; ❑Yes ❑No
Describe reason for that doctor visit____
Date of **Last Physical Exam** __________ Type of doctor and where performed ________________________
Have you ever seen a chiropractor? No Yes: Last adjustment/visit date: ___________
Chiro Name ____________________________________ **Phone** ____________________ **State** _______

Print Your Name ________________________________

Describe Current Complaints

Date major symptoms started or became worse________________

Please rate your symptoms in the column on the right (1-10: 1 being the least serious, 10 the worst)

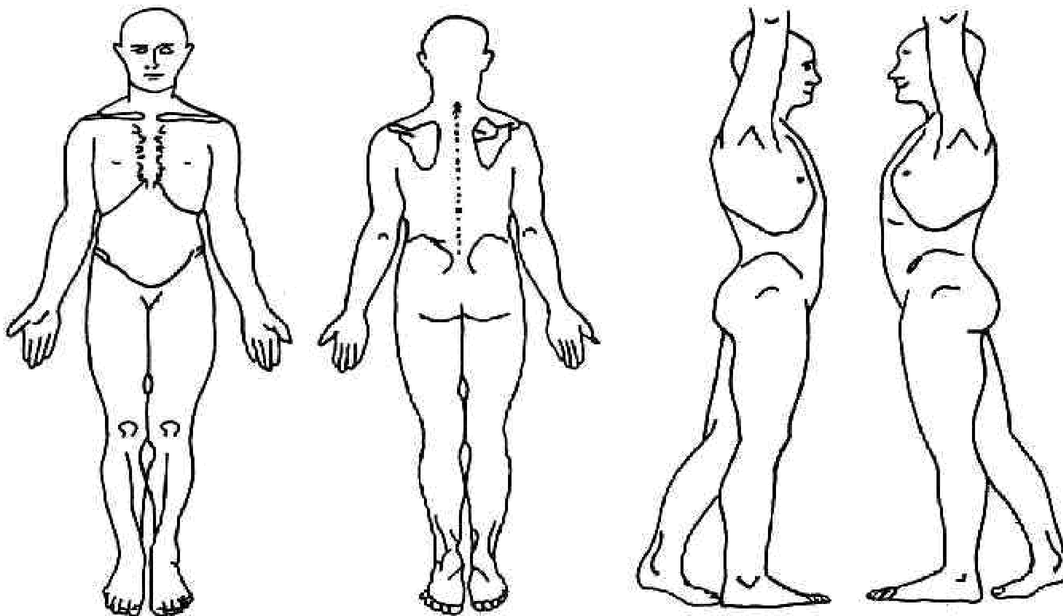
Complaint	Pain Rating	Date started
1(worst)________________________________	________	__________
2.________________________________	________	__________
3.________________________________	________	__________
4(least worse)________________________________	________	__________

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

WHAT ACTIVITIES DO YOUR SYMPTOMS INTERFERE WITH? Example: "Hard to stand and wash dishes. Hard to turn my head while driving. Trouble sleeping, etc." ____

____

Mark the figure below where your symptoms occur: **X**= Sharp Pain, **D**=Dull Pain, **A**=Aching pain, **N**=numbness, **B**= Burning pain, **T**= tingling, **R**= radiating or shooting pains



Print Your Name ________________________________

SYMPTOMS CAME FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑ SPORTS INCIDENT

❑HOME INCIDENT ❑OTHER ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET

If current symptoms are from an accident, DATE INJURY/ACCIDENT:__________ Briefly describe ____

IF NOT leave blank and continue.

Since my problems began my symptoms have persisted for: # ______HOUR(S) ______DAY(S) ______WEEK(S) _______MONTH(S) _______YEAR(S)

MY MAJOR SYMPTOMS/COMPLAINTS: ❑ COME & GO with no pattern

OR:

❑ ARE CONSTANT (76-100% of the day)
❑ ARE FREQUENT (51-75% of the day)
❑ ARE OCCASSIONAL (25-50% of the day)
❑ ARE INTERMITTANT (25% of the day)

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING DURING BOWEL MOVEMENT
❑STANDING >1 min ❑STANDING >10 min ❑COUGHING
❑SITTING IN GENERAL ❑SITTING >10 min ❑TURNING HEAD (RT or LT, both)
❑LIFTING ❑WALKING ❑LYING DOWN
❑SLEEPING is difficult due to pain (laying on back, rt side, lt side, all positions)
❑OTHER____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑BENDING ❑SITTING ❑STANDING ❑MASSAGE ❑HEAT ❑COLD
❑STRETCHING ❑LYING DOWN ❑RESTING ❑CHANGING POSITIONS
❑OTC MEDS ❑PRESCRIPTION MEDS (list)_________________________________

❑OTHER ____

ACCIDENT HISTORY

❑Job ❑Auto ❑Other 1. ______________________________________Date:___________

____

❑Job ❑Auto ❑Other 2.______________________________________Date:___________

____

Print Your Name ________________________________

❑Job ❑Auto ❑Other 3.____Date:______________

____

❑Job ❑Auto ❑Other 4.____Date:______________

____

Food Allergies if known: ____

Servings of vegetables eaten per day (average day) ___________

Servings of fruit eater per day (average day) ______________

Do you take a multi vitamin ? No Yes: Brand ______________________

Individual vitamin/herbs taken regularly in the past month (list brand if known)

____

____

MEN: Erectile issues? ❑NO ❑YES

Ladies: ARE YOU PREGNANT ❑NO ❑YES **DATE OF LAST MENSTRUAL PERIOD**___________

Are your cycles regular? Days _______ ❑YES ❑NO **Is your flow heavy, regular or light?**

Do you miss periods sometimes over the last few years? If so how many/often? ____________________

Cramps: Mild Med Severe **Do they make your back hurt ?** ❑YES ❑NO

Painful intercourse? ❑YES ❑NO

Everyone:

Do you have a weight problem? ❑YES ❑NO **Do you want professional help with it?** ❑YES ❑NO

Have you had a recent extreme weight gain or loss? ❑YES ❑NO

Frequent urination during the day? ❑YES ❑NO **If "Yes" How often** _______
Do you wake up at night to urinate? ❑YES ❑NO **If "Yes" How often** _______

Back pain during sex? ❑YES ❑NO

Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name ________________________________

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration
loss /confusion ❑constipation ❑depression ❑diarrhea ❑dizziness ❑face flushed
❑headaches ❑insomnia ❑light bothers eyes ❑poor balance ❑loss of smell
❑numbness in toes ❑pins-needles-arms ❑pins-needles-legs ❑ringing in ears ❑short of breath
❑stiff neck ❑stomach upset ❑trouble sleeping ❑high stress ❑weight issues
Other not listed: ____

SURGICAL HISTORY:

1.____ Date:________________

2.____ Date:________________

3.____ Date:________________

4.____ Date:________________

5.____ Date:________________

Have you ever had a metal implant?❑Yes(where_____________)❑No **Ever been gunshot?** ❑Yes_________ ❑No

Check ALL that apply to you now

Adrenal Health

I have plenty of energy during the day ______
I have a lot of energy during the evenings ______
I have low energy most of the time ______
I have periods of low and periods of normal energy ______

I frequently have trouble getting to sleep when I first lay down ______
I have sleep apnea ______
I wake at night and have trouble getting back to sleep ______

I have trouble with **High Blood Pressure** ______
I have a tendency towards **Low Blood Pressure** ______
I get light headed if I stand up too fast ______

I feel angry, aggressive or anxious a lot of the time ______
I feel like my head is in a fog ______

I've lost a lot of physical tolerance for exercise ______
Heart Palpitations, Atrial Fibrillation erratic heart beat ______

I have osteoporosis or osteopenia ______
I have High Blood Sugar (>100 fasting) or A1C (>5.0) ______

Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name ________________________________

As a result of my chiropractic care at this office I would like to:

Check all that apply.

❑ Feel Better quickly ❑ Have a healthier body and spine ❑ Live a better lifestyle

❑ Stay healthy with regular chiropractic check-ups so that my symptoms don't return again.

❑ Have a detailed Nutritional Assessment ***with lab work*** to find out what ***exactly*** how nutrition can help me improve my health and do my best at preventing poor health and disease later on in life.

❑ Have a basic Nutritional Consultation ***without lab work*** to find out how I can eat and feel better without medications.

❑ Stop taking my current prescription medications safely.

❑ Get health advice for my family.

❑ Refer a someone I know for chiropractic and/or nutritional care to this clinic.

I give ***Life Enhancing Wellness Centers, LLC*** (Dr. Kydonieus) permission to email me (if applicable) test results/private information to the email provided here.

Email: ____

Patient's Signature: ______________________________________ Date:________________________

If patient is a minor parent or guardian sign below

Guardian name (print) _______________________________ relation to minor patient______________

I give ***Life Enhancing Wellness Centers, LLC*** permission to test and treat
_________________________________ as a
(*Minor's name*)
patient. I also give my permission to treat my child in the future even if I am not present and send my child to this office (any location) with my appointed representative. If my child is of legal driving age but under 18 years of age and drives to this office for care and are alone I give my permission for them to receive treatment without me being present.

Legal Guardian, ____________________________________
Signature

All permissions can be revoked at any time in writing. Such letters must be mailed "certified" or given to this office in person, signed and witnessed. Email is not an acceptable form of notice to revoke said permissions noted above or elsewhere in this agreement. *Revised 03/06/2017

Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
Dr. Demetrios Kydonieus, Chiropractic Nutritionist

Print Your Name ________________________________

Leave the rest of this page blank when filling out forms.

Vitals
Ht __________ Wt ___________

Body Fat ____% **BMI** _________

B/P: Sitting ________ Pulse ______

Standing ________ O2 _______%

Supine _________ + - Ragland's Test

HRV ______ Symptom Score _______

DTR's

Triceps(C7) 1 2 3 4 5
Biceps(C5) 1 2 3 4 5
Brach (C6) 1 2 3 4 5
Pat(L5) 1 2 3 4 5
Achilles(S1) 1 2 3 4 5

____
____

Cervical ROM
F(60) ____ Pain _____________
E(50) ____ Pain _____________
RL(40) ____ Pain _____________
LL(40) ____ Pain _____________
RR(80) ____ Pain _____________
LR(80) ____ Pain _____________

Lumbar ROM
F(90) ____ Pain _____________
E(30) ____ Pain _____________
RL(35) ____ Pain _____________
LL(35) ____ Pain _____________
RR(30) ____ Pain _____________
LR(30) ____ Pain _____________

____
____

Jackson CC _______________ + -
Max Cervical ______________ + -
Brachial Dist ____________ + -
Distraction + -
George's + R, +L -
SLR +R, +L ______________ -
Braggard's +R, +L ___________ -
Yeoman's +R, +L ____________ -
Ely's +R, +L ______________ -
Minor's Sign + -
Kemp's +R, +L ____________ -
Fabre Patrick +R, +L -
Valsalva's __________ + -
SEMG : Mild Mod Sev Extreme
Thermal : Mild Mod Sev Extreme

Palpation: spasm, tenderness & trigger points
1-10 (10 is severe)

Occipital _________ R L bilateral not checked

Cervical _________ R L bilateral not checked
Thoracic _________ R L bilateral not checked
Traps _________ R L bilateral not checked
Lev Scap_________ R L bilateral not checked
Rhoms _________ R L bilateral not checked
Lumbar _________ R L bilateral not checked
QLumb _________ R L bilateral not checked
Gluts _________ R L bilateral not checked
Psoas _________ R L bilateral not checked
Hams _________ R L bilateral not checked
Quads _________ R L bilateral not checked
Calves _________ R L bilateral not checked

Upper arm ________ R L bilateral not checked
Forarm flex ________ R L bilateral not checked
Forarm ext _________ R L bilateral not checked
Rotator Cuff ________ R L bilateral not checked
Shlder(delts) ________ R L bilateral not checked

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