



BREATH
OF LIFE
wellness center

TERMS OF ACCEPTANCE

Please Read Carefully

Wellness Care enables each individual to maximize his or her health. Health can only be maximized when the major cause of interference is removed and balance is obtained.

Health: A state of optimal physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity. Health will be maximized if all obstructions to it are removed.

Subluxation: An imbalance of health due to nervous system interference in the spinal column, cranium and/or contiguous structures of the body. The result is a lessening of the body's inborn "innate" ability to express life at maximum potential.

Adjustment: An adjustment is the special application of forces to facilitate the body's correction of subluxation. Our method of correction is by specific adjustments of the spine, contiguous structures and soft tissues.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. We believe any named condition is merely a physical manifestation and not necessarily indicative of the underlying cause. Our only objective is to remove interference to the expression of your body's infinite wisdom, thus returning your body to balance.

We do not offer to diagnose or treat any disease or condition. However, if during the course of examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we give you the option to seek the service of a health care provider who specializes in symptom based care.

The CSA System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help in recommending a program to restore each system and meridian (energy pattern) to balance.

I understand that the Electrodermal Stress Analysis Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If you suspect that you need further medical intervention, you should consult your physician.

I give my permission for the testing technician to evaluate me on the CSA System. I understand that by doing so THE TESTING TECHNICIAN IS **NOT** BECOMING MY PRIMARY CARE PHYSICIAN.

I understand that the testing technician will give me information about myself based on the evaluation and the testing technician will make recommendations to improve my health based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician or Breath of Life Wellness Center responsible.

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 care on this basis _____
[Signature] [Date]

Since the patient is a minor and is being represented by another party, please sign below:

Personal Representative Name Personal Representative Signature Date

Relationship/Description of the authority to act on behalf of this patient.



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NOTICE OF PRIVACY PRACTICES

Please Read Carefully

In the course of your care as a practice member at Breath of Life Wellness Center, your personal information may be used or disclosed in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital, should you choose concurrent care.
- Your health care and billing records may be disclosed to another party, such as an insurance carrier or your employer, with your expressed written consent.
- Your name, address, phone number, and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to obtain a copy of the information we will use for these purposes. You also have the right to refuse authorization for this office to contact you regarding these matters. Your decision to refuse authorization will not affect the care you receive in any way.

Under Federal Law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but we believe, in our professional judgment, that you intend for us to provide care.
- If we are ordered to do so by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made with your express written authorization.

We normally provide information about your health to you in person at the time of your appointment. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or in a different format, please advise us in writing of your preferences.

You have the right to inspect and copy your health information for seven years from the date 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. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

State and Federal Laws require us to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

Furthermore, we are required by 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



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practices, we will notify you in writing as soon as possible following the changes. Any change in our privacy practices will apply to all your health information on file.

Information used or disclosed 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 the Federal Privacy Rule.

This notice is effective as of **September 1, 2007**. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Since the patient is a minor and is being represented by another party, please sign below:

Personal Representative Name

Personal Representative Signature

Date

Relationship/Description of the authority to act on behalf of this patient.

PATIENT AUTHORIZATION FOR CONTACT REGARDING WELLNESS CARE, RELATED HEALTH SERVICES, AND/OR RELATED HEALTH PRODUCTS

Under Federal Law we are required to ask for your permission to leave a message regarding confirming your appointment times and meetings and informing of products. The purpose of this use is to make a more pleasant, personable, efficient, and productive Wellness Center as well as further enhancing your access to quality health care.

If you choose not to authorize this information use, your decision will have **not** effect your care in this office or your relationship with our staff.

Your signature indicates your authorization of this activity.

____ Please check here if there is an alternate number where a message may be left.

Please enter the phone number here: (____) _____-_____.

Name

Signature

Date

You may revoke this authorization at any time in writing. Please allow 2 weeks for this change to be completed.



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Pediatric Health Appraisal (PHA)

Child's Name _____ Child's Nickname _____

Address _____ Home Phone _____

_____ Sex M/F

DOB _____ Referred By _____

Reason for Visit: _____

Family Information

Mother's Name _____ Father's Name _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Parents' Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

List Ages of Other Children In Family

Name: _____ Age _____ Name: _____ Age _____

Predominant language used at home _____



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Pregnancy History

During your pregnancy, did you have any of the following:

Please describe:

Yes No

- Falls?
- Motor vehicle accidents?
- Near-miss car accidents?
- High blood pressure?
- Diabetes?
- Anemia?
- Morning sickness?
- Indigestion?
- Seizures?
- Swollen ankles?
- Thyroid problems?
- Heart problems?
- Back pain?
- Abnormal bleeding?
- Were you hospitalized?
- Did you have any other illnesses?

During your pregnancy, did you use any of the following:

Please describe:

Yes No

- Tobacco?
- Alcohol?
- Non-prescribed drugs?
- Prescription medications?

Medication and Reason:



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Newborn History Birth to 2 Months

How many hours does your baby sleep between feeds?

During day _____ At night _____

Yes No

- | | | |
|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> | Does baby go to sleep easily? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby have a preferred sleeping position? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby cry if you change this sleeping position? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby have any feeding difficulties? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Is baby being breast fed? | If no, for how long was baby breast fed? _____ weeks/mos |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby have a one sided feeding preference? | Preferred breast Left / Right |
| <input type="checkbox"/> <input type="checkbox"/> | Is baby formula fed? | Which formula / milk source? _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby frequently spit up after feeding? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby cry a lot? | How many hours each day? _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby pass a lot of intestinal gas? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby have a preferred head position? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby frequently arch his/her head and neck backwards? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Does baby cry or become irritable during a diaper change? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Has baby ever had a fever? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Has baby had any falls? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Has baby been in a car accident or near-miss? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Has baby had any other trauma? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Has baby been vaccinated? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Do you have any other concerns you wish to discuss? | _____ |



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Infant History 2 months - 2 years

Yes No

- | | | | |
|--------------------------|--------------------------|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Can your child sit unsupported? At what age did your child start to sit up? _____ months. | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child crawling? At what age did your child start crawling? _____ months. | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child walking? At what age did your child start walking? _____ months. | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child often trip and fall? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other concerns about your child's growth and development? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had colic? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any upper respiratory infections? | How often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had asthma? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child complain of back or neck pain? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child complain of pains in the arms or legs? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child complain of headaches? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had earaches? | At what age did the first earache occur? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | How frequently does your child have earaches? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your child's earaches usually occur in the same ear? | Right, left, or both? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any other illnesses? | Please list each illness and its approximate date:

_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child currently taking any medications? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever been cared for in the emergency room? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever been hospitalized? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child been vaccinated? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been diagnosed with neurological disease? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other concerns about your child's help? | _____ |



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Pre-School Child History
3 years – 5 years

Yes No

Does your child complain of pain or discomfort?

If yes, when did this occur? _____

Onset (please circle one): Sudden Gradual

Problem (please circle one): Constant Intermittent

Has your child ever had this problem before?

Has your child been treated for this problem?

By whom? _____

Has your child had chiropractic care before?

Chiropractor's name: _____

HEALTH HISTORY

Does your child ever complain of back or neck pain?

Does your child complain of pains in the legs or arms?

Does your child complain of headaches?

Has your child had asthma?

Is your child allergic to anything?

Are there any smokers in the child's home?

Has your child had earaches?

At what age did the first earache occur? _____

How frequently does your child have earaches?

_____ Which ear? Right Left Both

Is your child taking any prescribed medication?

Please list any other illnesses which have been a concern for your child:

Please list any surgeries your child has had:

Please describe any other concerns you have about your child's health:



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TRAUMA

Yes No

- Has your child had any recent falls or trauma? Description & Date: _____
- Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____
- Has your child ever fallen down stairs or fallen from a significant height? _____
- Has your child ever been in a motor vehicle collision or near-miss? _____
- Has your child ever had a bone fracture or joint dislocation? _____
- Does your child ever bang his/her head repeatedly against a wall, bed, or other object?
- Has your child had any recent falls or trauma? Description & Date: _____

NUTRITION

Yes No

- Do you have concerns about your child's diet? _____
- Does your child have any food allergies? _____
- Does your child get skin rashes? _____
- Does your child take vitamin supplements? _____
- Does your child eliminate stools each day? _____
- Do you have concerns about your child's diet? _____

For how many months was your child breast fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of food does your child like to eat? _____



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School-Age Child History 6 years and Older

Reason for today's visit? _____

When did this problem first occur? _____

Yes No

Have you had this problem before? _____

Have you been treated for this problem? By whom? _____

Have you previously been to a chiropractor? When? _____

ABOUT YOUR HEALTH

In the past year, have you had any of the following:

Yes No

Back or neck pain? _____

Arm or leg pain? _____

Headaches? _____

Asthma? _____

Allergies? _____

Earaches? _____

Falls from a bicycle, skateboard, scooter, rollerblades, or similar? _____

Do you have a problem with bedwetting? _____

Have you ever been in a motor vehicle accident? _____

Have you ever had any broken bones? _____

Have you ever had any surgeries? _____

Are you at present taking any medications? _____

Do you have any other health problems? _____

ABOUT YOUR LIFESTYLE

What grade are you in at school? _____

How do you carry your school book? _____

How heavy is your book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend at the computer? _____

How often do you play video games? _____



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On average, how many hours sleep do you get each night?

Are there any smokers in your family?

Do you feel stressed out?

Do you have trouble reading the board in class?

Do you have blurred vision?

Do you wear glasses or contacts?

Do you get headaches when you read?

ABOUT YOUR DIET

What do you usually eat for breakfast?

What do you usually eat for lunch?

What do you usually eat for dinner?

What snacks do you eat after school?

What is your favorite food?

How much water do you drink each day?

How many sodas do you drink each day?

How often do you eat fast food?



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Payment Policy

Payment is expected at the time of appointment. We will accept cash, check, credit card, or Care Credit. We do not currently accept insurance, Medicaid, or Medicare.

Appointment Cancellations & No Shows:

When you schedule an appointment, that time is set aside for you. It is important for you to let us know immediately and at least 24 hours in advance when you need to cancel an appointment, as we have an extensive waiting list. No-shows are charged at a regular fee for the amount of the scheduled appointment.

I, _____ agree to the terms listed above.

Signature

Date

The information I have provided is accurate and true to the best of my knowledge.

Signature

Date

Thank you for completing this questionnaire. We look forward to serving you!