Welcome to Radiant Life Chiropractic

Our mission at Radiant Life Chiropractic is to help you achieve all of your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, and spinal x-rays.

There are a few simple steps for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing.

At your initial visit, please bring all completed paperwork (6 pages total, not including this one) and any previous X-ray or MRI reports, or recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our office prior to your visit.

PLEASE NOTE:
Because we block special times for new patients, we have a 24-hour cancellation policy where the initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 215-259-5100. Late arrivals do run the risk of requiring a rescheduled appointment.

Informed Consent

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including chiropractic care, massage therapy, and nutritional services. The purpose of chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called subluxations. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

Chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Radiant Life Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

We look forward to a healthy relationship with you and your family.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Whom may we thank for referring you to this office? _____

APPLICATION FOR CARE AT RADIANT LIFE CHIROPRACTIC

GENERAL INFORMATION

Please fill out the forms *completely* and *accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: _____ Social Security Number (SSN): _____-_____-_____

Name: _____
Last First Middle Initial

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email _____

Cell Phone Number: _____ Home Phone Number: _____

Gender: Male _____ Female _____ Age: _____ Birth Date: _____-_____-_____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Do You Have Insurance: Yes_____ No_____

Your Employer or School: _____Occupation: _____

Spouse's Name:_____ Spouse's Employer: _____

EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _____

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) _____

If this condition is due to an accident, we require you to fill out our accident history form

X-RAY CONSENT

I hereby give my consent to Radiant Life Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of above signature Relationship to Patient

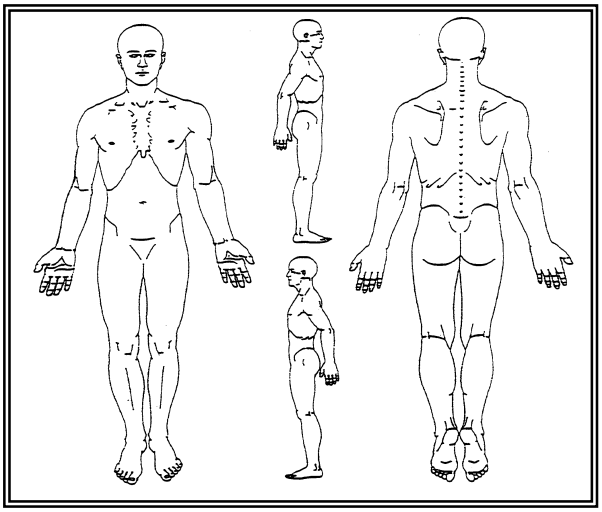
YOUR VISIT

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain-related issue, PLACE LETTERS on the image to the right to show the type of pain you feel in each location.

R=Radiating B=Burning
D=Dull A=Aching
N=Numbness T=Tingling
S=Sharp/Stabbing



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limite
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____
Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

List any MDs or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____
Other (please describe) _____

What makes your problem worse? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____
Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____
Telephone _____ Going from Sit to Stand _____ Other (please describe) _____

MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

_____

_____

Please list any injuries or surgeries you have had over the course of your life: _____

_____

Are you allergic to any medications? Yes _____ No _____ If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use: _____

_____

_____

_____

FAMILY HISTORY

Mother: Living _____ Deceased _____ List any medical problems: _____

Father: Living _____ Deceased _____ List any medical problems: _____

List any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____

Stroke _____ Arthritis _____ Scoliosis _____ Thyroid disease _____ Osteoporsosis _____ Other (describe) _____

SOCIAL HISTORY

Do you have any children? Yes _____ No _____

If yes, how many and what ages? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much and how often? _____

Do you smoke? Yes _____ No _____ If yes, how much, how often and how long? _____

What do you do most of the day in your job postures, positions and repetitive movements? _____

_____

On a scale of 1 to 10 (1= Worst and 10= Best) rate how well you think you are doing with the following:

Exercise _____ Sleep_____ Diet _____ Ability to Manage Stress _____ Water Intake _____ Energy Level _____

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

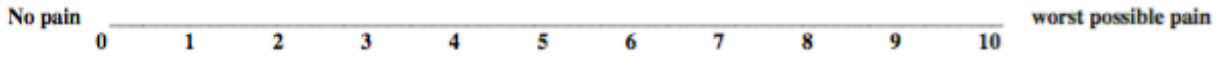
0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	**Energy / Activity:** _____ Fatigue / Sluggishness _____ Apathy / Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating / Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety / Fear / Nervousness _____ Anger / Irritability / Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal / Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred Speech	**Mouth and Throat:** _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints / Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge

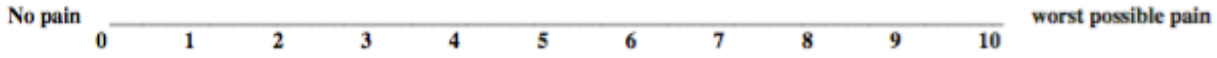
QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:
Directions: Please circle the number that best describes the question being asked
Note: If you have more than one complaint, please answer the question for each individual complaint and indicate the score for each complaint.

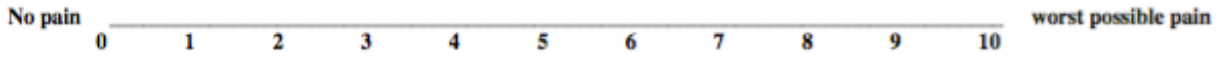
1. What is your pain RIGHT NOW?



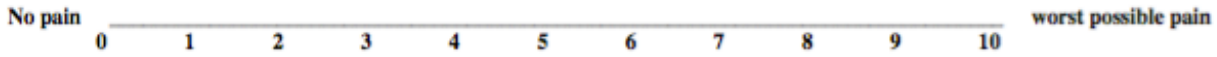
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain level AT ITS BEST (How close to "0" does your pain get?)



4. What is your pain level AT ITS WORST? (How close to "10" does your pain get)



OTHER COMMENTS:

_____

_____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993.

I hereby authorize payment to be made directly to Radiant Life Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Radiant Life Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**