KEYSTONE
CHIROPRACTIC
& SENSORY DEVELOPMENT CENTER

Terms of Acceptance

When an individual seeks Chiropractic healthcare and is accepted as a client for such care, it is essential for both to be working towards the same objective. It is important that each client understand both the objective and the method that will be used to attain it.

Adjustment:	An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. The chiropractic method of correction is by specific adjustment of the spine.
Health:	A state of optimal physical, mental, emotional, and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation:	A misalignment of one or more of the 24-36 vertebra in the spinal column which causes alteration of nerve function and interference between brain and body communication, resulting in a decreased ability for the brain and the body to express its' maximum health and life potential.

I do not offer to diagnose or treat any diseases or condition other than vertebral and joint subluxations. However, if during the course of a chiropractic spinal examination, I encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis, or treatment for those findings, I will recommend that you seek the services of another health care provider.

I, _____, have read and fully understand the above statements.
(Print first and last name)

_____ _____
(Signature) (Date)

Address: _____

City: _____ State: _____ Zip: _____

Email: _____
*by sharing your email we'll send you our monthly newsletter, you can always opt out later.

Phone # _____ (carrier: _____)

I would like to receive appointment reminders and schedule changes via **text messages**?
□ yes □ no

Signature of examining doctor _____ Date: / /

KEYSTONE
CHIROPRACTIC
& SENSORY DEVELOPMENT CENTER

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Emergency Contact: _____#_____relation: _____

How were you referred? _____

Reason for seeking services: _____

Ever received chiropractic care? __ Y __ N; for how long? _____
Date of last visit: _____ Why did you stop? _____

Anything about your spine or nervous system we should know about (injuries)?
_____

History of **Physical** Stress, Trauma, or Challenges:
_____

History of **Chemical** Stress, Trauma, or Challenges: *(includes food challenges)*
_____

☐ I would like to know more about food sensitivity/allergy testing?

History of **Emotional** Stress, Trauma, or Challenges:
_____

☐ I would like to know more about our emotional release technique utilized in our office.

Tell me about the Following:
Diet: _____ Fluid Intake: _____

Sleep & Rest: _____ Exercise: _____

Drugs (OTC, script, recreational): _____
Below is per day
Alcohol: ___ *(drinks)* Tobacco: _____ Coffee/Caffeine __ *(glasses)* Soda: __ (cans)

Your goals: **(check all that apply)** __ Relief and prevention of a symptom/problem
__ Relief of a symptom or problem
__ Healthier spine and nerve system
__ Optimal health on all levels

I have answered everything above to the best of my ability.

Print: _____ Sign: _____

Signature of examining doctor _____ Date: / /