LIFE LOUNGE CHIROPRACTIC and HEALTH CENTER 632.1892
*info@thelifelounge.ca* *www.thelifelounge.ca*

# WELCOME!!!

**PERSONAL INFORMATION:**

Name: ______________________________________________________________
First Middle Last

Address: ______________________________________________________________

City:________________________ Postal Code: ____________ Prov: ______

**Email: (mandatory)**______________________________

Home Phone: _______________ Cell: ________________ Business: _____________

Birth Date: Month: ________________ Day: ____________ Year: _________

Occupation: ________________________ Employer: ___________________________

Marital Status: ______________________ Name of Spouse: _____________________

Previous Family Chiropractor: __________________________________________________

Reason for Leaving: _________________________________________________________

Present Physician: ___________________________ City: _____________________

**COULD YOU HELP US????**

**It is Important for us to know how you FIRST DISCOVERED our clinic**

Facebook First?___________

YouTube First? ___________

Google First?_____________

Friend/Family/Co-worker( please specify name of person)________________________

Community Event_______________________________________________________

OTHER_______________________________________________________________

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**PERSONAL HISTORY**

Name: ________________________________

Main Concern: _____________________________________________________________

Other Concerns: ____________________________________________________________

How long have you suffered with this problem? _________ Days Months Years

How did it start? **Accident Sports Injury Lifting Stress Birth Trauma**

**Job Duties Gradual Other** ___________________________________

Have you become discouraged or stressed coping with this problem? **YES NO**

This problem interferes with my: (circle) **Work Family Hobbies My Life**

What aggravates the problem? **work movement lying down sitting Other:**_____________

Circle the frequency of your problem/discomfort: **Constant Intermittent Cyclical**

How do you attempt to alleviate the problem?

**Hot / Cold Compress Rest Stretching Exercise Massage Naturopathy Yoga Acupuncture**

**Drugs**_________________________________________________________

**Surgeries (specify)** ___________________________ **Other** _______________________

Please outline your previous accidents/injuries ________________________________________

Date of Accident: ___________ Are you aware of any resulting problems? _______________

What is your commitment level to achieve total health? (Highest = 10) 10 9 8 7 6 5 4 3 2 1

Is there any other information you would like us to be aware of? __________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Signature:** ______________________________ **Date:** __________________________

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## PHILOSOPHICAL AGREEMENT & CONSENT

From the moment of conception until our last breath we have a Life Force that is transmitted from our brain to our body and from our body to our brain.

The nervous system is the system in the human body that is used for the transfer of the electrical signal and operating instructions for all of our organs, tissues and glands…for EVERY PART OF US!

It is the most efficient, specialized, sophisticated, complex and delicate biological system that exists in the universe. In fact, it is so closely interwoven with the immune system that leading edge scientists feel that they can almost be considered one system!

A free flow of nerve signals throughout the body is mandatory for health and proper body function. Chiropractic adjustments realign the spine and pelvis to allow better nerve communication and overall health. Every person, young or old, should have their spine checked for misalignments.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. Chiropractic specializes in the detection, location and correction of nerve interference, and restoration of spinal alignment.

Some say there are very slight risks associated with it. We have NEVER had ANY of these occur in our office, however, we feel that it is responsible to let you know the following:

Although not scientifically verified, there are reports in the profession of stroke, ligament, rib and/or disc injuries. IT IS IMPORTANT TO KNOW THAT NO CLINICAL SCIENTIFIC STUDY HAS EVER SHOWN CHIROPRACTIC CARE TO BE THE CAUSE.

In fact, the risk of injuries and complications is so small that chiropractors carry some of the lowest malpractice insurance fees of all the health care professions in the world. This is true because Chiropractic is one of the safest health care systems that exist on the planet.

It is not our goal to correct any physical problems other than vertebral misalignment and/or altered spinal structure.

If I become concerned about symptoms or conditions, I understand that I should seek the help of a symptom, sickness and disease care professional. Although chiropractors study and are trained in many of these areas during their education, our goal is to ensure the nervous system is free from Vertebral Subluxations and to correct altered spinal structure.

I have read and understand the above explanation and realize that I may review it with the doctors if I choose to discuss it further.

By signing this document I give my permission for the initial examination. If I choose to accept care after the examination; I consent to physical care provided by Dr. Brad Deakin and/or any other chiropractor practicing in Life Lounge Chiropractic and Health Center.

I have completely read and fully understand the above information. I choose to proceed with the examination and with chiropractic care (if I choose this option after the assessment)

**Name (please print):** ________________________________

**Signature:** ________________________________________ **Date:** ____________________________

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## OFFICE FINANCIAL POLICY

Below are the fees that exist in our office should you choose to be examined and possibly receive care at a point in the future.

If you choose to receive care, you will be required to pay for services in advance or when it is received. **We do not allow our patients to carry outstanding balances for care that has been received.**

**Health Benefits/Insurance:** Your health coverage is independent of our office and is between you and your insurance company. We will be happy to issue a receipt at any time to help you facilitate your claim.

| Service | | Fee |
|---|---|---|
| Consultation | | Complimentary |
| Initial Assessment, Spinal and Neurological Exam, Initial X-Rays | | $197 |
| Non-Surgical Spinal Decompression Session with chiropractic adjustment | | $225 |
| X-Rays | Up to 3 Exposures | $25 |
| | 4 or More | $50 |
| Chiropractic Adjustments | | $45 |
| Re-Evaluations (approx. every 20 visits or at Doctor's discretion) | | $50 |
| Home Traction Units | | $50 |
| Missed Appointments (without notification of 2 hours) | | $45 |
| Orthotics | | $650 (ask for clarification) |

X-Rays are that are not fully paid (at regular fees) are considered property of the clinic. This means that if a person wishes copies of their x-rays to take out of the office, full fees for the x-rays must be paid before the films are released. There are no exceptions to this rule.

I have read and understand the above information and agree to be examined. If care is required in the future, I accept care based on the fee schedule shown above.

I understand that I can discontinue care at any time, for any reason.

**Name (please print):** ________________________________

**Signature:** ________________________________________

**Date:** ____________________________________________

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# Consent to X-Ray

This office and doctor uses several techniques to make spinal and neurological improvements in our patients. To create this improvement, we utilize several different techniques to initiate *SPINAL RECONSTRUCTION*.

To provide specific knowledge and get the best results for our patients we take x-rays on patients. This allows us to know what is going on rather than guess what is going on.

As such, you may be required to get x-rays to assess your current state of spinal and neurological health. By signing this form, you acknowledge that there are mixed scientific opinions regarding x-rays…some studies say they are harmful while other, more recent studies indicate that occasional x-rays can actually be helpful in destroying weak tissue cells.

Regardless of which scientific position is correct, we strongly feel as though the benefit of getting x-rays dramatically outweighs any perceived risk.

Fees for x-rays (If they are not complimentary with your initial assessment) are as follows:

Partial Set (3 or less exposures) $25
Full Set (4 or more exposures) $50

**Please note that no x-rays are released from the clinic unless the regular fees are paid.**
Occasionally, some x-rays exposures are considered complimentary when a person is initially investigating their spinal health in our office. These films are considered property of the office and are not released from this office unless the full regular x-ray fees listed above are paid.

I understand and agree to the aforementioned and also verify that there is no possibility of being pregnant at the current time.

_____________________________ _____________________________ _____________

Printed Name Signed Name Date

Thank you,
The Life Lounge Team