LIFE EMPOWERED Chiropractic

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PATIENT INFORMATION FORM

Patient Name: _____ _____
Last First Middle Initial Date

Address: _____
Street

_____
City State Zip

Phone Numbers: (____) _____ (____) _____ (____) _____
Home Work Cell

Age: _____ Date of Birth: _____ Sex: Male _____ Female _____

Email: _____

Responsible Party (If other than patient)

Spouse/Parent Name: _____
Last First Middle Initial

Relationship to patient: _____ Phone Number: (____) _____

I hereby agree to guarantee payment on behalf of the above patient for all services rendered if not reimbursable under an insurance contract:

Signed: _____

Emergency Contact: _____

Phone Number: (____) _____ Relationship _____

I hereby authorize my attorney, representative, payers and/or agents to release any and all information that Life Empowered Chiropractic may request relative to my account or payment thereof. I understand that regardless of my insurance status I am financially responsible for services rendered that are not covered by insurance. I agree to pay all collection fees associated with collecting any account for which I am responsible. I also hereby authorize the release of any information for the purpose of insurance billing and authorize the assignment of benefits directly to my physician. Further, I hereby represent that all of the information contained in this form is accurate and current to the best of my ability.

Signed: _____

Date: _____

MEDICAL HISTORY

Major Accidents or Injuries

(Dates & Descriptions)

Surgeries

(Dates & Descriptions)

Medications

(Please list all medications you are currently taking)

NAET CONSENT FORM

I _____ certify that Dr. Tom Cahoon and associated health providers at Life Empowered Chiropractic do not claim to cure any illness or disease with NAET® (Nambudripad's Allergy Elimination Techniques).

I understand that NAET® is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET® gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET® uses various standard medically proven diagnostic measures and modalities (allopathic, chiropractic, kinesiological and acupuncture) to diagnose the patient's condition. The premise behind NAET® is to balance the energy of the individual patient to a substance(s) using NAET® (this procedure uses information from allopathic, chiropractic, acupuncture/acupressure, nutritional, and applied kinesiology) so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I (dependent) am to continue all medications and other treatments modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after I (dependent) get a life-threatening reaction from the allergen I (dependent) was given NAET® energy balancing procedures earlier or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency care, or by calling 911 or attending an emergency room at the local hospital. If I (dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, asthma, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (dependent's) symptoms under control while I (dependent) am going through NAET® energy balancing procedures. This way NAET® energy balancing procedures program can be satisfactorily completed on the basic allergens without interruption and once I (dependent) complete NAET® energy balancing procedures for my (dependent's) condition, I (dependent) may experience reduction of my allergic symptoms and improved quality of life.

I understand that for 25 hours after the NAET® energy balancing procedures, I (dependent) am to avoid eating, touching, breathing and coming within 3 feet or more as it was instructed by my practitioner of the substance(s) that I (dependent) have received energy balancing procedures for. If I (dependent) come in contact with the substance(s) for which I (dependent) am being energy balanced, I realize that the energy balancing procedures may not work and I (dependent) may have a sensitivity reaction.

I understand that I (dependent) must return after my 25 hours avoidance period, preferably within 24 hours but at least within 7 days, to determine if I (dependent) have cleared for the substance(s). I fully understand that I (dependent) may still experience a reaction to the substance(s) of unknown severity if I (dependent) come in contact with them if I (dependent) did not clear them completely. If I (dependent) did not clear them completely, I (dependent) may require to repeat the procedure (more office visits at my cost) until I (dependent) clear them satisfactorily.

I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

To be completed by patient:

_____
Print Name

_____
Signature of Patient

_____
Date Signed

To be completed by parent or guardian:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

_____
Relationship to patient

_____
Date signed

To be completed by doctor or staff:

_____
Witness to patient signature

_____
Translated by

_____
Date

_____
Date

CHIROPRACTIC CONSENT FORM

To the patient: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Tom Cahoon and associated health providers who now or will treat me at Life Empowered Chiropractic.

I understand and I am informed that, in the practice of chiropractic, there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I understand that I am consenting to the treatment plan and chiropractic care at my own risk. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Name

_____
Signature of Patient

_____
Date Signed

To be completed by parent or guardian:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

_____
Relationship to patient

_____
Date signed

To be completed by doctor or staff:

_____
Witness to patient signature

_____
Translated by

_____
Date

_____
Date

Please take a moment to look over the following list and answer the questions appropriately. Some of the things on the list may seem unrelated to your visit, but may play a role in the care you receive for your allergies.

Please check any of the following:

- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Consistent Fever
- ☐ Headaches
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Poor/Excessive Appetite
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Excessive Weight Loss/Gain
- ☐ Abdominal Cramps
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Lumps
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other _____
  _____

Do you have any allergies that you are aware of? ☐ Yes ☐ No

If yes, please list them

_____

Do you have any health concerns that might be related to allergies? ☐ Yes ☐ No

If yes, please explain

_____

Have you seen any other professional for these health concerns? ☐ Yes ☐ No

If yes, describe the treatment given

_____

Are there any other health concerns that were not addressed in this form? ☐ Yes ☐ No

If yes, please explain

_____

Have you ever had an anaphylactic reaction? ☐ Yes ☐ No

If yes, to what? _____ Do you carry an Epipen for this allergy? ☐ Yes ☐ No

Have you had blood work done for your allergies? ☐ Yes ☐ No

Please inform the doctor of any other concerns you may have. Thank you.