

HEALTH IS FREEDOM!

What to expect: You'll watch a 5 minute video to explain today's procedures, discuss your problems with Dr. Jardine, then the 165 point Functional Neurology Exam will take place. Don't worry- no needles!

Full name:	Birth date:	Age:	Date:
Home phone:	Cell phone:		
Address:	City:		Zip:
Email:	Marital status: M S W D		
Spouse/guardian:	Children?	#:	Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/>
Employer's name :	Work phone:	Do they hold Lunch & Learns? Y N	

Who referred you to our clinic? 😊 We like to thank them for giving us such a wonderful compliment!

Top Health Concerns:	Severity 1 =mild 10 =worst	How long?	Achy, sharp, radiating	Is this injury related?	Is this getting worse?	What have you done for it?	Family history of this?	This makes it worse:

★ **How does this interfere with your life?** On a scale from 1 to 10 (10 is all the time)

Work	Sleep	Daily Routine	Sports/exercise	Other
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Explain:

Other doctors you've seen for these concerns:	Phone
Chiropractor: " Limited Scope " (pain focused)	
Wellness Chiropractor: (Acupuncture, nutrition, EMG, workshops)	
Medical Doctors:	

List Medications (& non-prescription) Why?

List Supplements & homeopathic Why?

✦ Stressors: <i>The accumulation of stress over time in your life influences your health.</i>		
Physical Stress? falls, accidents, poor posture	Chemical? smoke, unhealthy food, not enough water, drugs- (recreational or prescription), pollution	Mental? work, relationships, finances, self esteem

Any surgeries, accidents or injuries?

Type:	When?
Type:	When?
Type:	When?

Health History

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Eczema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> High Blood Pressure

Diet: Do you eat this Daily (D) or Weekly (W)?

Alcohol	Bread/Pastries	Candy	Milk	Plain Yogurt	Steamed Vegetables
Tobacco	Fried Foods	Canned food	Fruit juices	Fish	Raw Vegetables
Coffee	Organic Food	Chips	Soda	Fruit	Cravings?

How healthy do you think you are? Grade yourself on a scale of 1-100, (1= Least 100 = Most)

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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Is there anything else which may help us better understand you?



CONSENT FOR CARE

Although Dr. Jardine receives a high percentage of great results with many conditions, I understand there is no guarantee of benefit, as health and results also comes also from my compliance with the treatment plan and my lifestyle choices. Individual results may vary depending on age, severity and length of time the condition has been present. I understand that to achieve the best results, I should follow Dr. Jardine's recommendations.

I understand the above information & consent to the evaluation and possible future care to be performed.

Patient Signature (or legal guardian)

Date of Birth

Date

FEEES FOR SERVICES RENDERED

New patient Evaluation \$265.00

"I understand the above information and acknowledge that I am responsible for the payment of all charges, due today upon end of visit."

Patient signature (or legal guardian)

date

CANCELATION POLICY

Your time is valuable, and so is ours. We thank you for giving us 24-hour notice for rescheduled appointments; otherwise a **\$80 fee** will apply.

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"



INSURANCE RELEASE

Dr. Jardine is an out of network provider, so we do not directly bill insurance companies. You will receive a SuperBill to send directly to your insurance company or Flex Spending account for reimbursement. Fees are payable in the form of Cash, Check or Credit Card- (Visa & MC) when services are rendered or a care plan is signed and arranged for. Reimbursements vary.

I understand & authorize release of my records necessary to process my claims.

Patient signature (or legal guardian)

Date