



Thank you for your interest in our wholistic approach to helping you be your healthiest self! We are committed to empowering you to see that *Wellness is Worth it* and you really can't afford to be sick! Having a Wholistic Doctor of Chiropractic on your health care team is a major step in solving problems and in keeping you active for as long as you live!

Here is what to expect:

BRIEF CONSULTATION

Dr. Jardine will listen and discuss your health problems with you to determine if you may benefit from care.

INITIAL EVALUATION

Dr. Jardine will be gathering information about your nervous system from physical exams, previous X-rays, MRI's or lab tests, Computerized Infrared Thermography (CIT) scan, EMG Scan and in-office X-rays if needed.

- The Thermography and EMG scans are painless devices used to detect irritation to the central nervous system (brainstem/spinal cord) by moving highly sensitive scanning devices on the sides of the spine.
- Specific X-rays detect how long problems have been present and what level of spinal decay is present in your spine that affects your health.

DOCTOR'S REPORT

Your second visit to our office will occur within the week to discuss the analysis and findings Dr. Jardine made of your test results. The treatment plan tailor-made and recommended for you will be discussed in full. You will now be ready to receive a personalized adjustment and high brain update.

CARE PLAN

Health is a process, not an event. Therefore, your health care plan will include a number of adjustments to retrain the nerve/muscle habits to provide stability and healing for your problems. These visits occur more frequent at first, and then reduce in frequency in later months as healing occurs. The care plan is determined by your exam results, the severity of the condition, length of time the condition has been present, and your age. Please be advised that the care plan recommended by Dr Jardine should be followed correctly for best results.

OTHER HEALTH CARE PROVIDERS

Dr. Jardine's care can occur in conjunction with other forms of health care (procedures, treatments, therapies, massage & medications) except for other chiropractic adjustments. To achieve your best results here, avoid other adjustments and osteopathic manipulation. You should not discontinue any other health care or medications without consulting with your other providers.

Please turn the page over

PATIENT INFORMATION

Name (*print*): _____



Date: _____

Age: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____

Home Phone: (____) _____ - _____ Cell phone: (____) _____ - _____

Email: _____

Home Address: _____

Zip: _____

Occupation: _____ For How long? _____

Did someone refer you to our clinic? If so, please let us know so that we can thank them for giving us such a wonderful compliment:

Please describe your Main concern (s), or what brings you to our clinic?

On a scale of 1-10, how health would you say that you are? _____



"Be honest—how much are you exercising?"

ADULT CONSULTATION HISTORY



- How long have you suffered with this problem? _____
- What have you tried to do to get rid of this problem that DID NOT work? _____

- What do you do that makes this problem worse? _____
- Does this problem make you feel older than you are? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following areas of your life?

Work: _____

Hobbies: _____

Family: _____

Life: _____

Does handling this problem case stress for you? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you temporary relief? _____

What is the pattern of this problem? Constant Daily on & off Weekly Monthly

What is the effect this has on your body functions? _____

Do you remember when/how it started? _____

Medications: What are you taking at this time?

Supplements: What are you taking now? _____

Have you **recently** been involved in an automobile accident? Yes No Date of accident: _____

Any health difficulties from this? _____

Do you have any children or a spouse? Yes No If children, how many? _____

Would you like to know how their central nervous system is functioning by receiving a complementary gift certificate for a complete examine by Dr. Jardine within the next 2 weeks? Yes No

Is there any other information you'd like us to know? _____

Signature: _____ *Date of birth* _____ *date* _____

For Women only:

Date of your last menstrual period: _____

Do you experience severe cramping with menstruation? Yes No

Do you suffer from PMS? Yes No

Please turn the page over



CONSENT FOR CARE

While Dr. Jardine has received a high percentage of results with a variety of conditions, I understand that there is no guarantee of benefit, as health comes also from my choice of compliance and lifestyle. Individual results may vary and depend on several factors including age, severity and length of time the condition has been present. I understand that Dr. Jardine will discuss with my any limitations my case might present as well as the probability for successful results. I understand that to achieve the best results, I should follow Dr. Jardine’s care plan recommendations.

“I understand all the above information and give consent for the chiropractic evaluation and care to be performed by Dr. Jardine.”

Patient Signature (or legal guardian)

Date of Birth

Date

FEE & INSURANCE INFORMATION

Dr. Jardine does not directly bill insurance companies, but will give you a receipt that you can send directly to your insurance company for reimbursement. Fees are payable in the form of cash, check or credit card when services is rendered unless other arrangements have been made in advance. Please be advised that chiropractic for insurance companies vary and your company may or may not cover out-of-network chiropractic services; may have limitations on the number of visits; and/or may have a deductible or exclusions. Dr. Jardine is not a participating provider with any insurance company, PPO, HMO’s or Medicare.

RELEASE OF INFORMATION (for insurance purposes)

I authorize Dr. Carrie A. Jardine, D.C. to release any office records necessary to process insurance claims.

Patient Signature (or legal guardian)

date of birth

date

FEES FOR SERVICES RENDERED (subject to change)

Brief Consultation	Complimentary
New patient Evaluation	\$200.00
Specific X-rays needed	\$65.00

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

CANCELATION POLICY

Your time is invaluable, as is Dr. Jardine’s. Please give 24-hour notice for cancelled or rescheduled appointments otherwise a **\$75 fee** will apply.

Patient signature (or legal guardian)

date of birth

date