The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to correct these layers of damage and recover your innate health potential.

Let’s begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

**About Your Health**

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to correct these layers of damage and recover your innate health potential.

**Loss of Wellness**

Let’s begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

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<th>Yes</th>
<th>No</th>
<th>Patient Comment if answer is Yes</th>
<th>Chiropractor's Comment</th>
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**1. Birth Process**

- Was the delivery long?
- Was the delivery difficult?
- Forceps?
- Caesarean?
- Breach/cephalic?
- Home birth?
- Hospital birth?
- Mother given drugs during delivery?
- Was labor induced?

**2. Growth and Development**

- Were you taught how to care for your spine?
- Did you fall out of bed?
- Were you a head banger or rocker?
- Where you breast fed?
- Childhood sickness?
- Accidents?
- Surgery?
- Drugs?
- Did you fall while learning to walk?
- Were you picked on by siblings?
- Child abuse?
- spanking(how?)
- pulled ear/chin
- Other
- Chair pulled out when you sat down?
- Did you fall down stairs?
- Were you yanked by your arm?
- Did you have other traumas? What? When?
Finally, the years of continuing damage showed up as acute or chronic symptoms.

Other Symptoms:
- Have you been under drug and medical care?
- What side effects have you experienced from the drugs and surgery?

Chiropractic provides three types of care. The first is Initial Intensive Care which corrects the most recent layer of the Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then, begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.
Insurance Information

Patient Last Name ___________________________ First Name ___________________________ Middle ___________________________

Insurance Type (Check all those that apply)

Self Insurance
(Consumer Directed)

☐ Personal Health Insurance
(not sponsored by employer)

☐ Health Savings Account (HSA)

☐ Other ___________________________

Employee Sponsored
(Private Sectors)

☐ Group Health Insurance

☐ Self Funded Benefit Plan

☐ Private Schools

☐ Health Reimbursement
Arrangement (HRA)

Governments
(Public Sectors)

☐ Medicare Part B

☐ Medicaid

☐ Municipal
(city, state, etc.)

☐ Other ___________________________

Other Types

☐ Auto Injury

☐ Workers’ Compensation

☐ Church

☐ Other ___________________________

Insurance We need a copy of your cards for our records.

Insurance Company ___________________________
Insured’s Name ___________________________

Insurance Company ___________________________
Insured’s Name ___________________________

Insurance Company ___________________________
Insured’s Name ___________________________

Insurance Company ___________________________
Insured’s Name ___________________________

Responsible Party Complete this section if you are not the patient but are responsible for the bill.

Responsible Party ___________________________

Relationship to Patient ___________________________

Home Address ___________________________

City ___________________________ Apt# ___________________________

Home Phone # ___________________________

Employer Name ___________________________

City ___________________________

Work Phone # ___________________________

SS# ___________________________

Apt# ___________________________

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally, financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co payments, or non-covered services as may be required by my insurance plan.

_____________________________ Date

Signature of patient or person acting on patient’s behalf

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

_____________________________ Date

Signature of patient or person acting on patient’s behalf
Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absences of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for these findings, we will recommend that you see the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body’s innate wisdom. The Power That Made The Body Can Heal The Body.

Our only method is specific adjusting to correct vertebral subluxations.

Minor Release:
I, ___________________________________ Being the parent or legal guardian of ________________________________ have read and fully understand the above Terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

I, ________________ have read and fully understand the above statements.

All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____________________________________  ____________________________
Signature                           Date
Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Dr. Randolph J. Penn's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Dr. Randolph J. Penn's "Notice of Privacy Practices" prior to signing this document. Dr. Penn's "Notice of Privacy Practices" has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Randolph J. Penn, D.C. The Notice of Privacy Practices for Randolph J. Penn, D.C. is also provided on request at the main administration desk of his practice. This Notice of Privacy Practices also describes my rights and Dr. Penn's duties with respect to my protected health information.

Randolph J. Penn, D.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________  ______________________________
Signature of Patient or Personal Representative                           Date

______________________________
Name of Patient or Personal Representative

______________________________
Description of Personal Representative's Authority
Email Signup Form

Our office communicates to our patients via conventional mail and e-mail. Please provide your email address below. By doing so, you are giving Penn Chiropractic Centre, Dr. Penn, and staff permission to contact you via mail and e-mail. We will not sell, rent or give away your contact information to any outside entity.

E-mail Address ____________________________________________________________

Full Name ___________________________ Date ________________________________

Signature _____________________________________________________________________