

What, if anything, makes the problem feel better?

Does this interfere with your: (circle one) Liesure Work Sleep Sports Other

Describe:

Have you seen other doctors for this condition? Chiropractor MD Other

Name/ Address

Date / / Diagnosis:

General History

Please list all medications you are taking, and why: (Prescription and not Prescription)

Have you had any surgeries and/or hospitalization? Yes No If yes, briefly explain:

Have you ever had any work related injuries? Yes No If yes, briefly explain:

Have you ever had any slips, falls, or auto accidents? Yes No If yes, briefly explain:

On a scale of 1 to 10 (**1=none, 10=extreme**), describe your emotions/psychological/lifestyle stress levels:

Scale = Occupational stress:

Scale = Personal stress:

On a scale of 1 to 10 (**1=poor, 10=excellent**), describe your habits and condition as it relates to:

Eating Exercise Sleep General Health Wellness Lifestyle

Please circle all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | |
|------------------------|------------------------|------------------------|
| Headaches | Depression | Eyes bothered by light |
| Pins & needles in arms | Constipation | Stomach upset |
| Pins& needles in legs | Menstrual Pain | Diarrhea |
| Dizziness | Menstrual Irregularity | Cold sweats |
| Numbness in fingers | Hot Flashes | Mood swings |
| Fatigue | Irritability | Loss of smell |
| Sleeping problems | Cold Hands | Loss ot taste |
| Tension | Cold Feet | Back pain |
| Ulcers | Fever | Neck pain |
| Buzzing in ears | Urinary problems | Stiff neck |
| Ringing in ears | Fainting | Numbness in toes |

Your Goals

At our office we're concerned about your *health* and *wellness goals*. Please take a moment to list your goals.

Wellness Goals

Physical (Be Fit):

Nutrition (Eat Right):

Lifestyle (Think Well):

Please check all that are relevant:

<input type="checkbox"/> Purchase bottled water	<input type="checkbox"/> Would you like to know more about: Proper Nutrition and diet
<input type="checkbox"/> Belong to a health club	<input type="checkbox"/> Proper exercise routines and techniques
<input type="checkbox"/> Take vitamins or supplements	<input type="checkbox"/> How to deal with Lifestyle stress

The above information is true to the best of my knowledge. I understand that I am financially responsible to pay for all services at the time of service as they are rendered and cannot be deferred to a later date.

Patient/Guardian signature

Date

INFORMED CONSENT

I request and consent to examination and analysis by Dr. Marshall Dickholtz, Jr., and staff related to Atlas Subluxation Complex Syndrome. This request includes, but is not limited to, permission for Dr. Marshall Dickholtz, Jr., his associates and staff to perform structural and neurological evaluations and adjustments based primarily in NUCCA's protocol by Dr. Dickholtz, Jr., as may be determined appropriate by them.

The undersigned patient understands that Dr. Dickholtz, Jr. has concentrated his practice on the analysis and adjustment of Atlas Subluxation Complex Syndrome. This condition causes stress to the central nervous system and displaces the patient's center of gravity from their vertical axis. This stress can also affect the peripheral nerves that radiate throughout your body, causing spinal and body distortions to then develop. Adjustments are **ONLY** given when the stressor at the brain stem level (top of the spinal cord) is detected. Adjustments are not necessarily given on every office visit. Since an adjustment uses very little depth, the patient feels very little, if any, force.

An adjustment of the Atlas Subluxation Complex Syndrome does not address all aspects of health. I understand that Dr. Dickholtz, Jr. strongly recommends that I obtain regular examinations from my personal medical physician for overall diagnosis and care of condition and/or ailments that may not be due to or respond to the effect of the vertebra or vertebrae that should be balancing the head. The risks and possible consequences of adjustments and the possibility of complications have been explained to me. I acknowledge that no guarantee or assurance has been given by anyone as the result of the adjustments. I am aware that success of any case depends on factors beyond the control of the doctor including compliance by the patient with all instructions and directions.

I have read and understand this **INFORMED CONSENT** and I have had the opportunity to ask questions concerning this form and possible care.

Patient Signature

Date