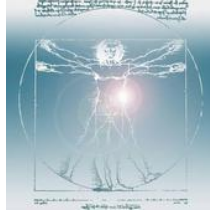


Ron Engler, DC, PTA, LDHS
Redlands Chiropractic & Wellness Center, LLC



Helping you take charge of your health

Patient Introduction

Name _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Work # _____

Email Address: _____ Sex: M F Marital Status: M S D W

Date of Birth _____ Age _____ Insurance _____

(We will need a copy of your photo ID on file to comply with HIPPA laws.)

Occupation _____ Employer _____

Spouse's Name & Occupation _____

In case of emergency, contact _____ Phone # _____

Relationship _____ Referred by _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- None of the above

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

Patient or Guardian Signature _____ Date _____

Printed Name _____



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C. Allergies: _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Deaths in immediate family: _____
 Cause of parents or siblings death _____ Age at death _____

5. Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

Patient or Guardian Signature _____ Date _____

Printed Name _____



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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems
 Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body
 Headaches Memory loss Tremors Vertigo Loss of sense of smell Strokes/TIAs
 Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes
 Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections
 Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation
 Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools
 Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____
 None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive
 Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
 Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use
 Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____
 None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery
 Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia
 Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If applicable, I authorize my insurance to be billed on my behalf so that I may be reimbursed for services received by Redlands Chiropractic & Wellness Center, LLC.

Patient or Guardian Signature _____ Date _____
Printed Name _____

2148 Broadway, C3, Grand Junction CO 81507 970-243-5164

www.redlandschiropracticgi.com



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HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient or Guardian Signature _____ Date _____
Printed Name _____



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Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient or Guardian Signature _____ Date _____
Printed Name _____



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Symptom 5 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient or Guardian Signature _____ Date _____
Printed Name _____



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Our Services & Fee Structure

Please note that fees for your initial visit include an exam and adjustment.

Consultation:	Complimentary
Examination:	\$ 75.00 (adult, teen age 15-17) \$ 44.00 (child age 0-9) \$ 50.00 (child age 10-14)
Spinal Adjustment/Treatment:	\$ 52.00 (adult, teen age 15-17) \$ 26.00 (child age 0-9) \$ 32.00 (child age 10-14) \$ 45.00 (Medicare & senior rate, 65+ for non-Medicare)
Pre-pay package of 10 adjustments/treatments:	\$ 450.00 (adult, teen age 15-17)

If needed and applicable, ask about our Medicaid rates for exams & adjustments.

Comprehensive Nutritional Evaluation:	\$ 550.00 <i>Includes urinalysis lab workup, interpretation and 5 exams</i>
24-Hour Urinalysis lab workup and interpretation:	\$140.00 plus overnight shipping cost
Two Nutritional Exams:	\$100.00 (Adult) \$ 75.00 (Child)
HealthLight Therapy:	\$ 25.00/session \$ 240.00/package of 12 (<i>for established patients only</i>)
Orthotics (FootLevelers):	Prices vary, starting at \$299

Emergency Chiropractic after hours will be billed at 1 ½ times the above applicable rates.

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

I fully understand the above fees and give my consent.

Patient or Guardian Signature _____ Date _____

Printed Name _____



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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine that do not involve bringing a joint past its physiological limit. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

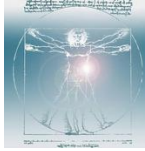
Date

Consent to evaluate and adjust a minor child: I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name

Signature

Date



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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you with appointment and/or missed appointment reminders, including leaving voice mail or answering machine messages. We treat in an open room where other patients may be present and may overhear some of your protected health information during the course of care. Should you need to speak with your physician at any time privately, the physician will provide a room for these conversations

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient or Guardian Signature _____ Date _____

Printed Name _____