HANDS 2 HEALTH WELLNESS CENTER

HANDS2HEALTH.COM | 626.358.3800

I would like to welcome you to Hands 2 Health Wellness Center. I'm Dr. Theresa L. Smith, Chiropractor founder of this healing arts and pain center. Within Hands 2 Health Wellness Center are also other practitioners; acupuncturist, massage therapist, reiki practitioners and more.

I practice Zone Technique which helps you heal by finding and fixing any disturbances in the signals between your brain and your body.

Imagine that your body is a bit like an electrical system, powered by six "circuits" that formed in your brain during your embryonic stage of development. These six "circuits" regulate and influence:

1. **Your glands**
2. **Your elimination process**
3. **Your nervous system**
4. **Your digestive organs**
5. **Your muscle system**
6. **Your circulation**

When your body experiences and responds to emotional, physical, or chemical stress, you experience a disruption in the normal function of one or more of these circuits. It's a bit like that circuit "shorted out." The results of a "short circuit" can create symptoms in the body…….from headaches and pain to indigestion, depression, insomnia, and everything in between.

Before I make an adjustment, I palpate six specific points on your head to determine which of your brain's "circuits" is out of harmony with the bodily systems they control. When I find the circuit that has shorted out, then I make a specific chiropractic adjustment that stimulates specific points on your spinal cord.

These adjustments allow a proper flow of signals between the spinal cord and the "circuits" in your brain that need balancing. The balanced "circuit" can then send the proper signals back to the malfunctioning system in your body. The result is that your body becomes better able to heal itself.

This is what we mean when we say the Zone Technique "balances your body."

If you are having issues, once a week is the typical recommendation for working on getting all your systems in top order.

I am committed to using all the tools I have to assist you in your health journey. Before starting on this journey, ask yourself, how committed are you to your healing journey? It is not a problem to see you once or twice, but I want you to realize that the results you will get will not be as great as coming in once a week. This is a journey that involves my working on your body and also, you taking responsibility for your body and your healing. Initial here that you understand this: ___________

Date: ________________________________

Name: ____

Address: ____ **City / State / Zip:** ___________________________

Occupation : ____ **Date of Birth:** _____________________________

Best Phone #: ____

Who referred you? ___________________________________ **Email** _______________________________________

Do you go on Facebook? Do you like inspirational messages? What you put in your thoughts first thing in the morning, helps you set up the feeling for the day. You are invited to join this HealthTribe by subscribing to our Facebook page: https://www.facebook.com/transformationdc. Like the page, follow and choose see posts first, so the first thing you read are inspirational messages. Dr. Theresa also sends out short, informative, life-changing emails. To be added to this list, just initial here: ______________ .

PAYMENT AND FEE POLICIES

Payment is expected at the time of service. The office accepts Visa, MasterCard, Amex and Discover. If you are not able to pay at the time of service, please make other arrangements ***prior*** to your appointment. This will be much appreciated. Ask about different ways to arrange this payment.

If you have insurance, you will be provided with a SuperBill to submit with their claim form. The insurance company will reimburse you. Health and accident insurance policies are an agreement between an insurance carrier and you, the patient. If any information is requested from your insurance company, assistance will be provided. There may be an additional charge depending on the amount of assistance necessary. Returned checks will be charged a $100.00 handling fee in addition to the amount due.

Appointments must be cancelled at least 24 hours in advance. Last minute emergencies are understandable. If you are not able to make your appointment and do not give notice, since there are others waiting, an office visit fee comparable to the visit reserved will be charged.

I have read the payment policies. I understand and agree that all services rendered me are my responsibility. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that Dr. Theresa L. Smith, will prepare any necessary reports and forms to assist me in making collection from the insurance company and that there may be an additional charge for reports. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I consent, authorize and request Dr. Theresa L. Smith, to administer such treatment deemed advisable. I understand that above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my medical status.

Patient's Signature: ____Date: ________________________

Patient Name (please print):____

Please share your end results you desire for this healing journey:

____

____

What are the biggest challenges you have when it comes to your pain? Your symptoms?

____

____

____

____

What have you tried to do to resolve your pain, your symptoms? Are things better? Worse? Unchanged?

____

____

____

____

How did that work for you?

____

____

____

____

What is not resolving your chronic pain, chronic health issues, costing you? Not only financially, but personally, in your life?

____

____

____

____

How much longer are you willing to deal with your chronic pain, chronic symptoms?

____

____

Patient Name (please print):____

What do you want instead?

____

____

____

What would your life be like if you were able to get totally healthy? Totally out of pain?

____

____

____

On a scale of 1-10, ten being the high number, how committed are you to getting out of pain? ____________

As a healthcare practitioner, I believe health problems can come from bio-chemical imbalances due to poor nutrition or toxicity, hormone imbalances from stress, or neurologic problems from trauma.

I'd like to ask you about your history of trauma to see if there could have been any damage to your nervous system. The average child has 1,000 traumas by the age of 13 and we want to find out if you had more than the average number of traumas. When you were a child, were you accident prone? ________YES _________ NO

How many times a week do you think you fell down while running around? ____________________

Did you ever:

Physically rough-house with brothers or sisters?	◯ Yes	◯ No	# of times a week?	For how many years?
Fall off your bike?	◯ Yes	◯ No	# of times a week?	For how many years?
Play sports?	◯ Yes	◯ No	# of times a week?	For how many years?
Read with your neck flexed for more than 2 hours at a time?	◯ Yes	◯ No	# of times a week?	For how many years?
Pillow fights?	◯ Yes	◯ No	# of times a week?	For how many years?
Gymnastics, dance or cheerleading?	◯ Yes	◯ No	# of times a week?	For how many years?
Auto accidents?	◯ Yes	◯ No	# of times a week?	For how many years?

When was the first time you had this pain?____

Any idea what caused this? ____

____

____

Patient Name (please print):____

(Females) Are You Pregnant? ___ Yes ___ No

Is this affecting: ____ Home life ____ Work life ____ Hobbies ____ Sleep Please explain :

____

____

Are you being treated for any other health condition(s)? ____ Yes ____ No If yes, please explain

____

____

Have you ever received chiropractic care? ____ Yes ____ No If yes, please explain

____

Are you taking any medications? ____ Yes ____ No If yes, please detail :

____

____

Please list the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had:

____

____

Do you exercise? ____ Yes ____ No If yes, please describe:

____

____

Do you stretch or do yoga? ____ Yes ____ No

Do you eat a healthy diet? ____ Yes ____ No ____ Not sure

Do you drink alcohol? ____ Yes ____ No Do you drink soda, including diet soda? ____ Yes ____ No

Approximately how many ounces of water do you drink per day? __________________

Do you smoke? ____ Yes ____ No

Are you seeking better health overall? ____ Yes ____ No

How young would you feel if you didn't have these problems? So, you are ______ years old now and have had these problems for _________? So, getting rid of these problems you could feel how old? Would that be

Patient Name (please print):____

valuable to you? If I couldn't accept your case and your problems went on for another ten years without help, do you think you would get worse? __________________

Does it sound like a new approach to get rid of these problems would be a good idea? _______ Yes _______ No

Assuming that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan?

____

____

If you agree to treatment, then:

I, the undersigned, hereby give permission for treatment.

Thank you!

Patient's Signature ____ Date ________________

Patient Name (please print):____

CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

X		X		X	
	NECK		**ARMS & HANDS**		**HIPS, LEGS & FEET**
	Pain in neck		Pain in upper ___R ___L		Pain in buttocks ___R ___L
	Neck stiffness		Pain in elbow ___R ___L		Pain in hip joint ___R ___L
	Neck weakness		Pain in forearm ___R ___L		Pain down leg ___R ___L
	Pinched nerve in neck		Pain in hands ___R ___L		Pain in knee ___R ___L
	Muscle spasms in neck		Pain in fingers		Pain in ankle ___R ___L
	Neck feels out of place		Pines & Needles in arm		Pain in foot ___R ___L
	Muscle spasms in neck		Pins & needles in fingers		Weakness of leg ___R ___L
	Grinding/popping sounds in neck		Numbness in arm ___R ___L		Weakness of knee__R ___L
	SHOULDERS		Numbness in fingers		Leg cramps ___R ___L
	Pain In ____ Shoulder joint		Weakness in arm ___R ___L		
	Can't raise arm		Weakness of hand___R ___L		
	Above shoulder level		Hands cold ___R ___L		
	Over head		**LOW BACK**		
	Tension in shoulders		Low Back pain		
	Pinched nerve in shoulder		Lowback stiffness		
	MID-BACK		Lowback weakness		
	Mid-back pain		Pinched nerve in low back		
	Mid-back stiffness		Low back feels out of place		
	Pain between shoulder blades		Muscle spasms in low back		
	Pain from front to back				
	Muscle spasms in mid-back				

Patient Name (please print):____

CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

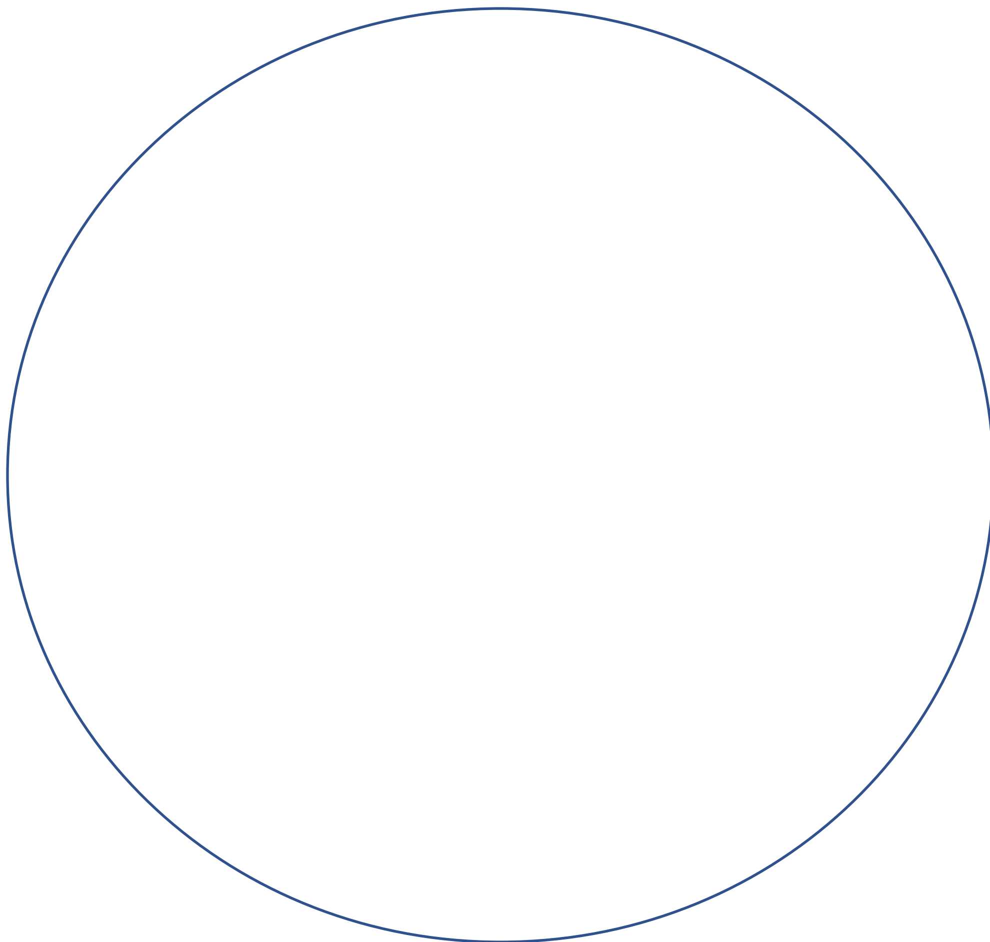
GENERAL	X	GASTROINTESTINAL	X	EYE, EAR, NOSE, THROAT
Bruise easily		Appetite Poor		Bleeding gums
Chills		Bloating		Blurred vision
Dental problems		Bowel Changes		Crossed eyes
Depression		Constipation		Difficulty swallowing
Difficulty Sleeping		Diarrhea		Double vision
Dizziness		Excessive hunger		Earache
Fainting		Excessive thirst		Ear discharge
Fever		Gas		Hay fever
Forgetfulness		Hemorrhoids		Hoarseness
Headache		Indigestion		Loss of hearing
Loss of sleep		Nausea		Nosebleeds
Loss of weight		Rectal Bleeding		Persistent cough
Nervousness		Stomach pain		Ringing in ears
Numbness		Vomiting		Sinus problems
Sweats		Vomiting blood		Vision – flashes
Tiredness		**CARDIOVASCULAR**		Vision – halos
Weight gain		Chest pain		**SKIN**
GENITO-URINARY		High blood pressure		Hives
Blood in urine		Irregular heart beat		Itching
Frequent urination		Low blood pressure		Change in Moles
Lack of bladder control		Poor circulation		Rash
Painful urination		Rapid heart beat		Scars
		Swelling of ankles		Sore that won’t heal
		Varicose veins		

X	MEN ONLY		WOMEN ONLY
	Breast lump		Abnormal pap smear
	Erection difficulties		Bleeding between periods
	Lump in testicles		Breast lump
	Penis discharge		Extreme menstrual pain
	Sore on penis		Hot flashes
	Other		Nipple discharge
			Painful intercourse
			Vaginal discharge
			Date of Last menstrual period:
			Have you had a mammogram?
			Are you pregnant?
			Number of children?
			Have you had thermography?

Patient Name (please print):____

Using the following list, map out how much time you spend on each in the circle below. You may also add activities.

1. **Fun; recreation, entertainment**
2. **Sleep**
3. **Work**
4. **Eating**
5. **Self-improvement**
6. **Proper sanitation**
7. **Exercise**



Patient Name (please print):____

Informed Consent to Chiropractic Treatment

Doctors of Chiropractic, Medical Doctors and Physiotherapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment. In particular, you should note:

a. While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.
b. There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment or manipulation to the neck (cervical spine). Vertebral
artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck and spinal adjustment or manipulation is extremely rare.
c. There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years.

These reports and studies have demonstrated that chiropractic treatment to be effective for spinal pains, headaches, and other similar symptoms. Chiropractic care may contribute to your overall well being. The risk of injuries or complication from chiropractic treatment is substantially lower than that associated with other treatments, medications, and procedures given for the same symptoms.

I, ___________________________________, acknowledge that I have discussed or have had the opportunity to discuss, with my chiropractor, the nature and purpose of my treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the treatments offered or recommended to me by my chiropractor including spinal adjustment. I intend this Consent to apply to my present and future chiropractic or physiotherapy care.

Dated this _____ day of ______________, 20___.

Patient Signature ____

Name (spelled out) ____

Witness Signature ____

Name (spelled out) ____

Patient Name (please print):____