My Life History

Privacy Statement: *The information you provide on this form is confidential. We will provide you and designated family members with this information by request only and will not use it for any purpose other than to aid us in providing you with the highest standard of wellness care that we are capable of giving. We appreciate your time and commitment to your ongoing health and well-being.*

Welcome to Thrive: A Chiropractic Wellness Center!
Please fill out the following questionnaire regarding your health history as completely as possible.
If you have any questions, feel free to ask the receptionist or doctor.

Name ______________________________ Social Security # ____________ Date ______________

Address ___________________________________ City _______________State _____ Zip _______

Home Phone __________________ Cell Phone ________________ Work Phone _________________

Email _________________________________ Birthdate ___________ Age _____ Gender ❑ M ❑ F

Occupation _____________________ Company Name ___________________________________

Work Address ______________________________ City _______________ State _____ Zip _______

Marital/Relationship Status ______________ Spouse's/Partner's Name ____________________________

Names/Ages of all Children ____

____

____

Reasons for seeking our services ____

____

What other action steps have you taken? ____

____

Who can we thank for referring you to THRIVE? ____

Have you ever been adjusted by a Chiropractor? ❑ Yes ❑ No When was your last visit? ________________

Who and Where? ____

____

Do you have a primary health care provider? ❑ Yes ❑ No

Who and Where? ____

____

Many of the health challenges that people face originate from stressors experienced not only as adults, but even before conception. These stressors (traumas) may be emotional, mental, physical, or chemical. Our goal is to help your body release stored/deep tensions and the more we know about you, the more we can help you with your healing process. *Please answer all of the following questions to the best of your ability.*

Birth history *(if known, please indicate all that apply to your own personal birth experience)*:

- ❑ bottle-fed formula
- ❑ breast-fed
- ❑ C-section
- ❑ doula
- ❑ epidural/meds in labor
- ❑ forceps delivery
- ❑ home birth
- ❑ hospital birth
- ❑ induced labor
- ❑ midwife
- ❑ mother smoked/drank/did drugs while pregnant
- ❑ vacuum extraction

History of Physical Stress, Trauma or Challenges *(please check all that apply)*

- ❑ active in sports
- ❑ alcohol or drug abuse
- ❑ arch supports
- ❑ broken bones
- ❑ car accidents
- ❑ dental work
- ❑ heel lifts
- ❑ hospitalizations
- ❑ no exercise
- ❑ not enough/poor sleep
- ❑ physical abuse
- ❑ repetitive lifting /bending /typing
- ❑ serious falls
- ❑ sit a lot/traffic
- ❑ sit on wallet
- ❑ surgeries
- ❑ work injury
- ❑ other injuries ______________ ___________________________

History of Chemical Stress, Trauma or Challenges *(please check all that apply)*

- ❑ alcohol use
- ❑ antibiotics
- ❑ caffeine/sugar/artificial sweetener
- ❑ cortisone injections
- ❑ drug use
- ❑ drug/alcohol overdose
- ❑ epidurals
- ❑ insulin
- ❑ over-the-counter medications
- ❑ poisoning
- ❑ poor diet
- ❑ prescription medications
- ❑ smoker past/present (# of cigarettes/packs per day ___)
- ❑ vaccinated
- ❑ work with chemicals
- ❑ other _____________________

History of Mental/Emotional Stress, Trauma or Challenges *(please check all that apply)*

- ❑ alcohol or drug abuse
- ❑ body image issues
- ❑ difficult divorce/break-up
- ❑ high family stress
- ❑ high job stress
- ❑ high personal stress
- ❑ hold in feelings
- ❑ loss of loved one
- ❑ made fun of/teased
- ❑ mental/emotional/sexual abuse
- ❑ money stress
- ❑ not valued
- ❑ physical abuse
- ❑ quick tempered
- ❑ recurrent physical/mental illness
- ❑ other _____________________

Nutritional History *(please check the items that apply to your typical diet)*

- ❑ alcohol
- ❑ artificial sweetener
- ❑ caffeine
- ❑ dairy-free
- ❑ energy drinks
- ❑ excess sugar
- ❑ gluten-free
- ❑ juice
- ❑ junk food (____ x/week)
- ❑ microwave food (____x/week)
- ❑ no breakfast
- ❑ omnivore
- ❑ other special diet
- ❑ raw food
- ❑ skip meals
- ❑ soda
- ❑ tea/coffee
- ❑ vegan
- ❑ vegetarian
- ❑ vitamins
- ❑ water (# of glasses per day _____)
- ❑ other _____________________

Has your body communicated any of the following to you? (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Chest pain
- ❑ Cold Hands/Feet
- ❑ Concussion
- ❑ Constipation/Diarrhea/Gas
- ❑ Depression/Nervousness
- ❑ Diabetes
- ❑ Digestions Problems
- ❑ Digestive Problems
- ❑ Dizziness
- ❑ Ear infections
- ❑ Extremity pain
- ❑ Fatigue
- ❑ Fever
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Conditions
- ❑ Heartburn
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Loss of sleep
- ❑ Loss of smell or taste
- ❑ Low back pain
- ❑ Mid-back pain
- ❑ Mood Swings
- ❑ Neck Pain
- ❑ Numbness in Arms/Legs
- ❑ PMS
- ❑ Rashes/Eczema
- ❑ Ringing in Ears
- ❑ Shortness of Breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Sweats/Chills
- ❑ Tension across shoulders
- ❑ Tension between shoulder blades
- ❑ Thyroid Problems
- ❑ Ulcers/Colitis
- ❑ Urinary Changes
- ❑ Vertigo
- ❑ Visual disturbances
- ❑ Weight Changes
- ❑ Other ___________________

For women *(please check all that apply)***:**

- ❑ birth control pills/patch/ring
- ❑ breast implants
- ❑ breast-feeding
- ❑ currently pregnant
- ❑ date of last period __________
- ❑ difficulty getting pregnant
- ❑ irregular cycles
- ❑ menopause
- ❑ miscarriage
- ❑ painful periods
- ❑ past pregnancy

Have you had or do you use any of the following for your growth, healing and development?

- ❑ Acupuncture
- ❑ Ayurvedic Medicine
- ❑ Breathwork/Re-birthing
- ❑ Cranial-Sacral
- ❑ Emotional Therapy/Psychotherapy
- ❑ Homeopathy/Herbalist
- ❑ Massage/Bodywork
- ❑ Naturopathic Medicine
- ❑ Nutritional Cleansing
- ❑ Nutritional Counseling
- ❑ Occupational Therapy
- ❑ Physiotheraphy
- ❑ Yoga/Pilates/Dance/Tai Chi
- ❑ other

Are you currently taking any medications (prescribed or over-the-counter)? ❑ Yes ❑ No ***If Yes, please list:***

____

____

____

My Commitment

What do you hope to receive from our care? (i.e. increased health, relief of symptoms, increased energy, greater flexibility, etc.) ____

____

What is your level of commitment to yourself, your life and your well-being?

Low 1 2 3 4 5 6 7 8 9 10 **High**

Authorization for Care
I hereby authorize the Chiropractor(s) to work with me through the use of adjustments to my spine, as she deems appropriate. The Chiropractor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I, ______________________________________, have completed this form to the best of my ability and have read the privacy statement and agree to the terms set forth by this office.

____ ____

Signature Date Parent/Guardian's Signature Authorizing Care Date

X-RAY CONSENT

The purpose of the x-ray examination to be performed is to analyze the spine for vertebral subluxations, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. I then must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I understand that seeking advice from another healthcare provider should not interfere with the subluxations correction care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

____ _________________________________

Signature Date

PREGNANCY RELEASE:

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

Date of last menstrual cycle: _____________________________

____ _________________________________

Signature Date

Understanding Our Service

When a person seeks chiropractic care, it is essential that the individual and the Chiropractor are working towards the same objective.

At Thrive: A Chiropractic Wellness Center, our mission is to help each member of our community improve their quality of life through chiropractic education and superior care in a loving and nurturing environment. We do this not only by alleviating pain, but also by focusing on the total health of our practice members and by encouraging and inspiring them to take an active role in their own health through chiropractic education. This allows us to restore the natural and delicate balance that exists in all individuals, therefore bringing our practice members into a higher state of optimal well-being.

Chiropractic adjustments enhance every aspect of your health. Health is defined as the state of optimal physical, mental, and social well-being, not simply the absence of disease or infirmity. As chiropractors, we use the chiropractic adjustment to correct subluxations that may be adversely affecting your health. Subluxations are misalignments of spinal segments that cause an alteration in nerve impulses and/or interfere with their transmission throughout the body. Adjustments are specific applications of forces delivered to facilitate the body's correction of these subluxations. Because the spinal column is in such intimate contact with your central nervous system (it is the protective housing for your brain and spinal cord), it is impossible to affect one without also affecting the other.

For some, physical, emotional, mental, and spiritual changes are immediate. For others, such changes are slower, or may feel incomplete or even non-existent. Yet, everyone will benefit from healthier nervous systems. Healing is a non-linear path, which means that one might experience ups and downs during a course of chiropractic care. This might include the experience of emotions, soreness, fatigue, and sensation awareness as subluxations are released and the body finds a new alignment. It also might mean greater energy, rest, ease, creativity, and connectivity.

Chiropractic is not a substitute, alternative, or preventative form of medicine. Chiropractic specializes in restoring balance to your nervous system, thereby enhancing your health and well-being. At Thrive, it is not our intention to diagnose, treat, or attempt to cure any physical, mental, or emotional ailments. The only diagnosis we make is that of subluxations. However, if during the course of chiropractic care something unusual is found, it will be brought to your attention. If you desire advice, diagnosis, or treatment for such findings, the chiropractor will recommend that you seek the services of another health care provider.

I, ____________________________________ the undersigned, have completely read and understood the above statements and choose to be served by Dr. Deva Usrey and/or Dr. Carol Ngo with this understanding for myself. All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_______________________________________   _______________________________________

Signature   Date   Signature of Parent/Guardian   Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can receive access to this information. Please review it carefully and thoroughly

In the course of your care as a practice member at Thrive, we may use or disclose personal and health-related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment, or care.

Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, HMO, PPO, or your employer, if they are or may be partially responsible for payment of your services.

We offer spinal adjustment s in an open room setting with other practice members in the same room. Occasionally, comments about your condition and care may be disclosed to other practice members or staff in the vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other practice members.

Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, birthday wishes, special occasions/events, information about alternatives to your present care, or other health-related information that may be of interest to you.

You have the right to refuse to provide authorization for this office to contact you regarding these matters. If you are not at home/work to receive an appointment reminder, a message will be left on your answering machine or voicemail, or with a family/staff member. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use and disclose your health information without your consent or authorization in these following circumstances:

If we are providing healthcare services to you based on the orders of another healthcare provider.

If we provide healthcare services to you in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for use to provide care.

If we are ordered by the courts or another similar agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from use. We may also mail information to you (via mail or internet services) regarding your healthcare or regarding the status of your account. Our office may also periodically send out personal mail (birthday cards, thank you notes, etc.). If you

would like to receive this information at an address other than your home or would like the information in a different form, please advise us in writing as your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created, or as long as the information remains in our files (whichever is longer). In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing.

You can restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to use at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

We are required by law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are also required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you would like further information, have a question or have a complaint regarding our privacy notice, or privacy practices, or any aspect of our privacy activities, please contact:

Carol Ngo, D.C.
Thrive: A Chiropractic Wellness Center
2571 North 1st Avenue
Tucson, Arizona 85719

This privacy notice is effective as of September 8, 2008. This privacy notice and any alterations or amendments made hereto will expire seven years after the date upon which you last received services from us.

My signature below acknowledges that I have read and understand both pages of the Thrive: A Chiropractic Wellness Center Privacy Notice. I authorize you to use or disclose my health information in the manner described in the notice. I also understand that I may receive a copy of this notice if requested.

____ ________________________

Signature Date