NEW PROFESSIONAL SERVICE CONTRACT

Paying Out-of-Pocket

- Hello & Welcome! I look forward to partnering with you to improve your quality of living!

- We believe that years of "stress" whether from any prolonged physical activity, or due to chemical issues from excess sugar in unhealthy foods or beverages, or from excess Advil, Aleve, Ibuprofen, Tylenol, or pain medications, from environmental toxicity, or related to emotional issues having to do with your job, money, finances, personal relationships or world events can affect one's level of pain, health, wellbeing and quality of life.

- Your initial holistic chiropractic session will include a consultation, physical examination, and holistic chiropractic treatment. Fees are $45 per 15 minutes; more or less time can be spent with your treatment session based upon your needs and your consent for treatment.

- Your sessions can be paid by cash, personal check, venmo, cash-pay and most major credit cards (a 4% surcharge wud be added to any credit card transaction to cover its bank fees).

- You wud accept a $25 for any returned insufficient bank check.

- You would agree to pay the full fee of your normal amount of timed visit unless you were to call Dr. Bob Seiler and as a professional courtesy you wud give a "24-hour notice" to reschedule or to cancel your appointment.

- I agree to have my credit card information securely on file which wud only be used for any missed appointment without giving a 24-hour notice for holistic chiropractic services, to purchase any organic / vegan / vegetarian / wholefood nutritional supplementation, for durable medical goods such as neck, wrist, knee braces, custom-made orthotics, or taping supplies.

- Medical reports / reporting if needed for your health records can be given at a fee of $225.00 per hour.

- Credit Card Information: Please Print Slowly & Legibly:

- Credit Card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

- Name As It Appears on Card: _____

- Billing Zip Code Associated with this Credit Card: _____

- Expiration Date: _ _ / _ _

  CVC: _ _ _

Patient's Signature: _____ Date: _____

Patient Print: _____ Date: _____

Doctor's Signature: _____ Date: _____

Doctor Print: Dr. Bob Seiler of Holistic Chiropractic & Subtle Energy Medicine

Enclosed is a copy for your records: _____Date: _____

Holistic Chiropractic & Wellness
Dr. Bob Seiler, Chiropractic Physician
150 S 600 E, Suite 6C, Salt Lake City 84102
801-230-0166

PATIENT INFORMATION

Name:_____ Date:_____

What You Prefer To Be Called: _____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Social Security #:_____

Age:_____ Birthdate:_____ Emergency Contact:_____

Address:_____ City:_____ State:_____ Phone:_____

Email:_____ May we email you our wellness newsletter? [ ] Y [ ] N

Who may we thank for your first visit? Referred By:_____ OR [ ] Website [ ] Google [ ] Other

Occupation:_____ Employer:_____

Work Address:_____ Work Number:_____

Significant Other's Name:_____ Do you have children? [ ] Y [ ] N Ages:_____

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

(Additional room provided to answer questions on the back of this form)

A. Reason for today's visit: [ ] work [ ] auto [ ] sports/competition [ ] trauma [ ] stress [ ] anxiety [ ] chronic [ ] other

B. Explain what happened:_____->

C. Please describe the pain intensity and its location on the included "Pain Diagram" page.

D. When did this condition begin? ___/___/___ Is it getting worse? [ ] Y [ ] N [ ] Constant [ ] Comes & Goes

E. Is this condition interfering with your: [ ] work [ ] sleep [ ] daily routine [ ] relationships Please explain _____->

F. Have you had this or similar conditions in the past? [ ] Y [ ] N Please explain_____->

G. Have you ever been treated by a Medical Physician for this condition? [ ] Y [ ] N If so, where_____->

H. Have you ever been treated by a Chiropractic Physician? [ ] Y [ ] N If so, for what_____->

I. Please list any falls, slips, concussions, or accidents you may have had with dates:_____->

J. Family Health History (genetics, your environment, epigenetics):_____->

K. The feet are the foundation of your body. Are you now wearing? [ ] heel lifts [ ] sole lifts [ ] inner soles
[ ] arch supports [ ] custom-made orthotics

SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS

[ ] High Blood Pressure
[ ] Cholesterol
[ ] Thyroid Imbalance
[ ] Insulin Resistance/Diabetes
[ ] Headaches: Migraine, Tension
[ ] Fibromyalgia
[ ] [ ] Weight gain/loss
[ ] Stress, Anxiety, Depression
[ ] Nightmares
[ ] Trauma: Physical/Emotional
[ ] Loss of Family Member/Friend
[ ] Insomnia
[ ] Mood Swings
[ ] Joint Pain
[ ] Posture
[ ] Fallen-arches
[ ] Extensive Alcohol/Drug Use

A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

Name:_____ Health History Intake Form Date:_____

Email: _____ Phone: _____

What are your health goals?

- ☐ Remove Pain
- ☐ Gain More Energy/Stamina
- ☐ Restore Health/Reduce Illness
- ☐ Achieve Optimal Wellness

What are your top 3 health complaints?

1)_____

2)_____

3)_____

Question	Y N	Patient Comment	Practitioner Comment
Are you on a particular diet or currently restricting certain foods?	Y N		
Do certain foods upset your stomach or cause constipation, IBS, or headaches?	Y N		
Do you have certain food cravings?	Y N		
Do you get shaky or anxious between meals?	Y N		
Do you drink **less** than half your body weight in water oz daily? (ex: if you weigh 150 lbs, 75 oz would be your daily water intake)	Y N		
Do you drink soda, sports, or energy drinks?	Y N		
Do you chew gum, drink diet drinks or consume sugar-free foods?	Y N		
Have you ever been unconscious, had a concussion, whiplash, closed head injury?	Y N		
Do you get muscle cramps, "charley horses", or eye twitches?	Y N		
Do you frequently use Tylenol, Ibuprofen, or other pain relief medications? (How many milligrams? How often?)	Y N		
Have you taken fish oil & had difficulty keeping it down?	Y N		
Do you have indigestion, belching, gas or bloating?	Y N		
Do you typically go **more** than 24 hours **without** a bowel movement?	Y N		
Have you had any organs surgically removed or medically altered? (appendix, gallbladder, etc.)	Y N		
Have you gained more than 15 lbs in the past year?	Y N		
Do you grind your teeth while you sleep?	Y N		
Do you have trouble falling or staying asleep?	Y N		
Have you had an illness that you have not fully recovered from?	Y N		

Do you have a health diagnosis or are you concerned with any of the following:

- ☐ High Blood Pressure
- ☐ Cholesterol
- ☐ Insulin Resistance (Diabetes)
- ☐ Thyroid Imbalance
- ☐ Arthritis
- ☐ Fibromialgia
- ☐ Cardiovascular
- ☐ Migraines/Headaches
- ☐ Stress
- ☐ Other_____

Please list all medications, supplements, and herbs that you a currently taking:_____

_____

_____

_____

_____

_____

Is there anything else you think I should be aware of: _____

_____

_____

_____

_____

General Pain Disability Index Questionnaire

Name (please print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Use the letters below to indicate the type and location of your sensations right now

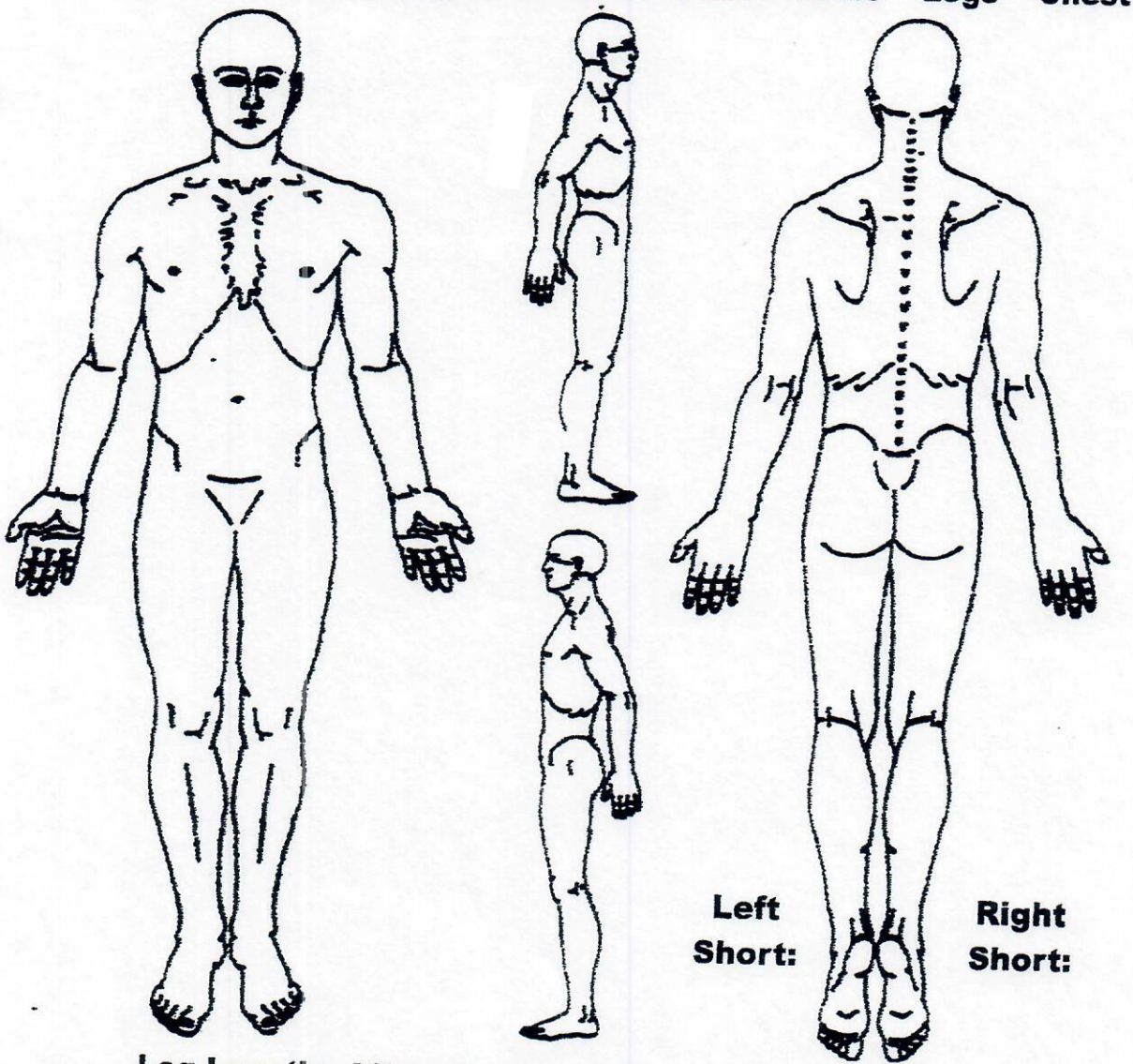
Key:

A = Ache
P = Pins & Needles.
B = Burning
S = Stabbing
N = Numbness
O = Others

Circle → R → Radiating into: Head Face Arms Legs Chest

Height:

Weight:



Left Short:

Right Short:

Leg Lengths Affect Physical - Emotional Stability

What activities do you do for exercise? _____

What activities are you unable to do? _____

DATE NAME: #

IMPORTANT: Please check (X) all present REVIEW OF SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroilliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:
- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R - L)
- Pins & needles in legs (R - L)
- Numbness of leg (R - L)
- Numbness of feet (R - L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R - L)
- Swollen feet (R - L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs /night
- Loss of weight _____ lbs.
- Gain weight _____ lbs
- ☐ Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

REV 11/94

Holistic Chiropractic & Subtle Energy Medicine
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Oftentimes, drawing/sketching with colored pencils/pens/crayons/watercolors can assist in expressing, and "getting in touch with" different feelings/emotions that are stored in your body and mind over a lifetime. Such feelings may be of pain, anger, hurt, sadness, isolation, aloneness, etc. I invite you to express any of your feelings through drawing, which could help Dr. Bob better understand what may be influencing what your body and mind are experiencing. Treatment for such can be incorporated into your recovery and therapeutic sessions.