Welcome to Jerviss Family Chiropractic.
Please Read Carefully.

It is of the utmost importance that you understand what to expect from this office.

STATEMENT OF PURPOSE

In this office we educate as many people as possible about the devastating spinal condition called VERTEBRAL SUBLUXATION. It is VERTEBRAL SUBLUXATION that destroys an OPTIMAL SPINE and thus destroys OPTIMAL HEALTH. Therefore, your experience here will not only be of healing, but also learning the truth about health.

CONFIDENTIAL PATIENT HEALTH HISTORY
(PLEASE PRINT CAREFULLY)

DATE_____
NAME (First, M. lnitial, Last)_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____WORK PHONE_____CELL PHONE_____
E-MAIL_____ Add me to the JFC Email List
BIRTHDAY_____AGE_____ SEX: M F
MARITAL STATUS: S M D W SPOUSE'S NAME_____
NAMES AND AGES OF CHILDREN _____
_____
OCCUPATION_____EMPLOYER_____

Have you ever been to a chiropractor?____ If yes, name of Doctor_____
How were you referred to our office?_____
Reason you came to our office_____
How long have you had this problem?_____
Are you willing to do whatever it takes to make a commitment to your health? Yes No Unsure

If you have VERTEBRAL SUBLUXATION, it can cause most of the unwanted conditions people suffer from every day. List any other past or present health concerns or problems: _____
_____

FEMALES: Are you pregnant? Yes No Not sure
PLEASE NOTIFY DOCTOR IF YOU ARE POSSIBLY PREGNANT

Method of payment for today's charges: Cash Check
Name of person responsible for payment_____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Jerviss Family Chiropractic will provide me with the necessary information to assist me in making my collections from my insurance company, and I am responsible for payment for all services rendered me. I understand that Jerviss Family Chiropractic is not a Medicare provider.

PATIENT SIGNATURE_____ DATE_____

Jerviss Family Chiropractic
Dr. Amanda F. Jerviss, Chiropractor

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, (print name)_____ have read and fully understand the above statements and give Jerviss Family Chiropractic permission to send information to me in the mail and to call me at the numbers I have provided to receive important information about my care and health.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _____ Date __ _____