



Our Purpose

A Statement of Clinical Objective

Hello, and welcome to our Network Chiropractic office.

My Purpose in sharing this statement of clinical objective is to clearly define my approach to chiropractic, healing, and those I serve in this office. I wish to clearly communicate to our responsibility in this exciting relationship.

The following concepts are central to the way in which I practice chiropractic. I am pleased to share these ideas with you so that our purpose can be in alignment from the very beginning.

- There is an intelligence within each individual, which not only keeps that person alive, but also animates, coordinates, repairs, renews, empowers and heals.
- The nervous system is a main coordinating system and distribution center for this innate intelligence.
- Alteration in the shape, position, tone or tension of the nervous system, at the spinal level, will block, inhibit or redirect the expression of this intelligence.
- Spinal subluxations are an interference to the proper functioning of the nervous system and its ability to send, receive and coordinate life force and intelligence.
- Proper coordination, repair, movement, inspiration, empowerment or healing cannot be expressed when this life power and intelligence is blocked or redirected.
- The purpose of the professional care in this office is to assist in the reduction of spinal cord tension and associated vertebral subluxations and to develop and maintain spinal and nerve system integrity. This empowers a greater communication of this life power and coordinating intelligence. A healthier spine, nervous system and enhanced health and quality of life is a desired outcome.
- Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible, elastic and subluxation-free spine and nervous system.
- Symptoms are not necessarily a sign of illness. They can occur to alert the individual of the need for change.
- Specific location of symptoms does not correlate to specific subluxations or areas of spinal tension needing to be adjusted. Severity of symptoms does not correlate to severity of subluxations. The reduction of symptoms is not an effective indicator of improved health.
- An individual may have symptoms and not need an adjustment on a particular visit. An individual may have no symptoms and may require extensive adjustments on a particular visit. A person's symptoms are not necessarily in direct relationship to his or her prognosis.



- I do not treat specific symptoms, conditions or ailments, other than vertebral subluxations. I do not imply that any particular adjustment or series of adjustments will have a direct effect on any symptom or condition a person may be presenting. Research studies show improved physical and emotional health and well being reported by thousands of patients receiving Network care.
- I encourage any individual having concerns about symptoms or ailments to consult with his or her physician at any time during care.
- Your innate intelligence is the true agent of healing, empowerment, coordination, inspiration, movement and joy. Healing is an inside job, coordinated by the same power which develops and renews your body.
- By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs, such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time for spinal correction.
- Medication levels for a non-flexible body-mind stuck in sickness are not necessarily the same as for a body becoming well.
- I will not venture into the practice of medicine by advising about the need for reduction of medications. I suggest you speak with your physician to determine the objective and goal to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind.

Sincerely,

Greg Muchnij, D.C.

I _____ have read this statement of purpose and understand its contents. I understand that the spinal adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and nerve system integrity. This office offers chiropractic as a form of health and wellness care, to promote the natural mechanisms for self healing and empowerment, as compared to specific target treatment.

Signature: _____

Date: _____



PERSONAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____
 Address _____
 City: _____ State: _____ Zip: _____
Phone Numbers:
 Home: _____ Business: _____ Cell: _____
 Fax: _____ E-Mail Address: _____
 Date of Birth: _____ Age: _____ Male _____ Female _____
 Married _____ Single _____ Divorced _____ Widowed _____ Number of Children _____
 Occupation: _____
 Social Security # _____ Insurance: _____
 How did you hear about our office? _____
 Name the family members who live at home with you _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY:

1. What do you hope to receive from chiropractic care in this office? _____
 Please List 2 or 3 specific health and wellness goals you would like to achieve with your care, IN THIS OFFICE:

2. Have you ever had your spine or nervous system examined professionally? Yes _____ No _____
 If yes, when and by whom? _____

3. Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? Yes _____ No _____
 If yes when was your last visit? _____
 For how long did you receive chiropractic adjustments? _____

4. How often did you go? _____ If you stopped, why? _____

5. Please describe what type of adjustments the chiropractor performed, or what technique(s) or methods he/she used: _____

6. Were you pleased with his/her service? Yes _____ No _____

7. Please Check the appropriate box next to each potential vertebral subluxation cause- either "P" for past or "C" for Current, and correct level of trauma: Mild, Moderate or Extreme.

	<u>Mild</u>	<u>Moderate</u>	<u>Extreme</u>		<u>Mild</u>	<u>Moderate</u>	<u>Extreme</u>
Falls from crib/carriage	P C	P C	P C	Sports Impact	P C	P C	P C
Falls down or up stairs	P C	P C	P C	Physical fight	P C	P C	P C
Falls on ice	P C	P C	P C	Armed Services	P C	P C	P C

8. Was your birth: _____ drug induced _____ forceps or suction
 _____ "C" Section _____ cord around the neck
 _____ breech _____ prolonged
 _____ natural _____ other: _____

9. Please write next to each spinal stress situation- Mild Moderate or Extreme. Please indicate "P" for past or "C" for current:

	<u>Mild-Moderate-Extreme-P-C</u>		<u>Mild-Moderate-Extreme-P-C</u>
Childhood stress	_____	Work-related stress	_____
School stress	_____	Stress of commuting	_____
Play or recreational	_____	Loss of a loved one	_____
Family stress	_____	Change in lifestyle	_____
Personal relationships	_____	Change in vocation	_____
Stress of being sick	_____	Abuse	_____



10. Were you ever knocked unconscious? Yes _____ No _____
If yes, explain: _____
11. Have you ever broken any bones? Yes _____ No _____
If yes,
explain: _____
12. Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine? Yes _____
No _____. If yes, explain: _____
13. Have you ever had extensive dental or orthodontic work performed? Yes _____ No _____
If yes, explain: _____
14. During the day I: _____ sit _____ stand _____ walk _____ do deskwork _____ phone work
_____ drive _____ do mechanical work _____ heavy lifting
15. I exercise: _____ daily _____ weekly _____ monthly Describe: _____
16. Do you have a particular position for watching television? Yes _____ No _____
If yes, explain: _____
17. I wear: _____ glasses _____ bifocals _____ contact lenses
18. Have you ever been involved in a vehicular collision or near collision (even as a passenger and even if you do not think you were hurt)? Please approximate dates and severity (mild, moderate or extreme):
Automobile: _____

Bus, bicycle, motorcycle, train, airplane, moped or other vehicles: _____

19. Have you ever been hospitalized? Yes _____ No _____
If yes, explain: _____
20. Have you ever had surgery? Yes _____ No _____
If yes, explain: _____
21. Have you had: _____ a spinal tap _____ spinal injections _____ physiotherapy _____ heel lift
_____ body part in a cast _____ traction _____ x-ray treatments _____ extensive diagnostic x-rays
_____ acupuncture _____ chemotherapy _____ transfusion _____ neck collar _____ corrective shoes
22. Are you now taking a drug (prescription or over-the-counter) regularly? Yes _____ No _____
If yes, please list drugs, when prescribed and reasons for taking them: _____

23. If you were previously taking any medication regularly, please describe: _____

24. Please list any vitamins or minerals you are currently taking and how often: _____

25. How do you grade your physical health: _____ excellent _____ good _____ fair _____ poor _____ getting worse
_____ getting better.
26. How do you grade your emotional/mental health: _____ excellent _____ good _____ fair _____ poor
_____ getting worse _____ getting better.

Thank you for choosing our office. We are excited about the possibility of assisting you as you continue on your journey toward greater health and wellness.

Name: _____

Date: ___ / ___ / ___

Please check **ONE** box (letters A-F) that best describes your **MAJOR COMPLAINT** area, then also check any symptoms you currently have.

A. NECK

- I ___ Muscle Spasm ___ Neck Pain ___ Neck Stiffness
 II ___ Headache ___ Tension ___ Dizziness ___ Nausea
 III ___ Arm Pain ___ Arm Tingling ___ Arm Numbness ___ Arm Weakness
 ___ Hand Pain ___ Hand Tingling ___ Hand Numbness ___ Hand
 Weakness
 Previous MRI or diagnosis of a cervical disk: ___ Herniation ___ Bulge
 IV Can't turn head: ___ Right ___ Left

B. UPPER BACK

- I ___ Tension in shoulders ___ Muscle Spasm
 II ___ Burning at top of shoulders (next to neck)
 II ___ Pain between shoulder blades ___ with burning
 II ___ Arm Pain ___ Arm Tingling ___ Arm Numbness ___ Arm Weakness
 ___ Hand Pain ___ Hand Tingling ___ Hand Numbness ___ Hand
 Weakness

C. MID BACK

- I ___ Spasm of ribcage muscles
 II ___ Difficulty breathing
 III ___ Difficulty twisting
 IV ___ Burning pain in back next to spine felt in front of chest
 IV ___ Any trauma to ribcage

D. LOW BACK

- I ___ Muscle Spasm ___ Low Back Pain ___ Low Back Stiffness
 II ___ Pain/Tingling down back of leg ___ to the knee ___ to the ankle or foot
 III ___ Previous x-ray diagnosis of Degenerative Joint Disease (Osteo Arthritis)
 IV ___ Leg Pain ___ Leg Tingling ___ Leg Numbness ___ Leg Weakness
 ___ Foot Pain ___ Foot Tingling ___ Foot Numbness ___ Foot Weakness
 ___ Previous MRI or Diagnosis of a lumbar disc: ___ Herniation
 ___ Bulge
 IV ___ Pain in front of leg to the knee ___ Pain/Tingling over top of hips

E. EXTREMITIES

- I ___ Shoulder Pain ___ Right ___ Left
 II ___ Elbow Pain ___ Right ___ Left
 III ___ Wrist Pain ___ Right ___ Left
 IV ___ Hip Pain ___ Right ___ Left
 V ___ Knee Pain ___ Right ___ Left
 VI ___ Ankle Pain ___ Right ___ Left

F. IF CURRENTLY PREGNANT

- I ___ Single Fetus ___ Breeched ___ Multiples



Office Policies

The Following will help you and your family to receive all the benefits chiropractic offers and help us achieve our mission.

1. Family Exams– It is our policy that everyone in the family be checked for subluxations within 14 days. It is not a requirement for them to be under care but it is mandatory for everyone to be checked. For those that need care we offer special family fees. _____ **initial**
2. New Patient Orientation– All patients are required to attend a minimum of one (1) new patient orientation within the first 30 days of care with their spouse. This session held at a local restaurant will enhance your understanding of chiropractic, teach you how to stay healthy, help you get the best results possible. You are invited to bring up to 4 adult guests (no children please) to share with them how chiropractic can improve their quality of life. _____ **initial**
3. Spinal Adjustments– You need to be quiet, relaxed, and focused on receiving the very best adjustment possible allowing healing in your body to be released. The doctor is very busy and needs to be very focused during your spinal adjustments. Due to time constraints, the doctor can only address lengthy questions by special appointment or by phone after patient hours. _____ **initial**
4. Appointment Make-up– In the event you must reschedule an appointment please reschedule it within the same week so that we can keep your spinal correction program on track. _____ **initial**
5. In Case of Absence– Dr. Muchnij needs to be away from the office several times per year to attend or teach conferences and continuing education seminars. During his absence, a highly qualified chiropractor will be here to care for you. _____ **initial**
6. Severe Weather– The office may be closed in the event of severe weather. Please call to be sure the office is open. _____ **initial**



Our office will bill your insurance company as a courtesy to you. The following list summarizes your responsibilities:

If your deductible has not been satisfied for the present calendar year, your insurance company will deduct the unsatisfied amount from our payment. You are responsible for reimbursing out office for your deductible. If you are experiencing financial hardship, we will accept small payments per visit until your deductible amount is satisfied. All insurance payments for services provided by our office must be sent directly to us. If, for any reason, an insurance check is mailed to you, do not cash it. The check needs to be endorsed and brought into our office within one week of receipt.

If your insurance company should terminate or change, you need to communicate this to us immediately.

If your insurance company denies payment of our claim because of your lack of response to their request for information, the responsibility of payment would then be yours.

We are available to assist you with completion of insurance forms or any other insurance-related issue. We appreciate your patience and involvement in ensuring our office is paid for the services we provide in good faith.

Patient Signature:

Date: