Confidential Information

Our goal is to help you with your health concerns as effectively and thoroughly as possible. Please fill out the information below with as much detail as possible.

First Name_____ **M.I.**____ **Last Name** _____
Address_____
City_____ **State**_____ **Zip**_____
Sex: M F **Marital Status:** ◯Married ◯Single
Social Security #_____-_____-_____ **D.O.B.**____/____/_____
Home (___)_____-_____ **Cell** (___)___-_____ **Work** (___)___-_____
Height _____ **Weight** _____**lbs. Drivers License #**_____
Email_____
Who referred you? _____
Current Employer_____ **Phone** (___)____-_____

Reason for Your Visit (please check ZYTO or EVOX)

☐ **ZYTO – Nutritional Biofeedback**
- ☐ Digestion/GI Functions
- ☐ Weight gain/loss
- ☐ Skin abnormalities
- ☐ Allergies
- ☐ Detoxification
- ☐ Hormones
- ☐ Autoimmune Disease
- ☐ Other_____

☐ **EVOX: What are some perception issues that you would like to work on?**
- ☐ Anxiety/panic attacks
- ☐ Confidence
- ☐ Performance – sports or professional
- ☐ Money/Prosperity/Financial
- ☐ Family/Transgenerational
- ☐ Unknown
- ☐ Other_____

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Neuro Muscular Connection may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for chiropractic and nutrition care by Dr. Steven Shaffer, DC and Keverne Collison CCN, HHP. You hereby grant full authority to Neuro Muscular Connection staff to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon you, which may be advised, or necessary.

All health information may be shared with _____ Relationship _____

PATIENT_____ DATE_____

SIGNED BY_____ RELATIONSHIP (if other than patient)_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor affiliated with Neuro-Muscular Connection. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests. I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor affiliated with Neuro-Muscular Connection to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I hereby authorize the doctor to treat my conditions he/she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid to the doctors for examination and treatment deemed necessary. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medical diagnosed conditions nor any medical diagnosis.

Patient Signature_____ Date _____

Guardian Signature_____ Date_____

Health Concerns

Health History:

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Weight Gain/Loss	**For Females Only**	
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	☐	☐ PMS
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder	**For Males**	
☐	☐ Cancer	☐	☐ General Fatigue	☐	☐ Prostate
☐	☐ Tumor	☐	☐ Muscular In coordination	☐	☐ loss of muscle
☐	☐ Asthma	☐	☐ Visual Disturbances	☐	☐ loss of libido
☐	☐ Chronic Sinusitis	☐	☐ Dizziness	☐	☐ lack of motivation

☐ ☐ Other:_____

Family Health History: (Cancer, Arthritis, Diabetes, Heart Disease, Kidney Disease, Etc.)

_____

List ALL surgical procedures you have had SINCE CHILDHOOD or are considering:

_____ _____ _____

List all prescription medications/ the over-the-counter medications you are CURRENTLY taking:

_____

Social History & Life Choices:

Alcohol:	◉Daily	○ Weekly	○Occasionally	○Never
Diet Foods:	○Daily	○ Weekly	○Occasionally	○Never
Energy Products:	○Daily	○ Weekly	○Occasionally	○Never
Fresh/Homemade Food:	○Daily	○ Weekly	○Occasionally	○Never
Soft Drinks:	○Daily	○ Weekly	○Occasionally	○Never
Water:	○Daily	○ Weekly	○Occasionally	○Never
Caffeine:	○Daily	○ Weekly	○Occasionally	○Never
Drugs:	○Daily	○ Weekly	○Occasionally	○Never
Tobacco:	○Daily	○ Weekly	○Occasionally	○Never
Exercise:	○Daily	○ Weekly	○Occasionally	○Never

California Health Freedom Act Disclosure

Homeopathy, Clinical Nutrition and Evox and Zyto practitioner are considered alternative therapies and are not a substitute for medical treatment. The information and therapy offered by Keverne Collison for her homeopathic, nutritional and Evox and Zyto does not include a diagnosis. Homeopathic remedies and nutritional supplements are available over the counter and are FDA approved.

In compliance with Section 2053.6 of Senate Bill SB577, Keverne Collison, discloses the following:

- That she is not a licensed physician in the State of California
- That the treatment is alternative or complementary to healing arts services licensed by the state
- That the service to be provided is not licensed by the state
- That the theory of treatment upon which this service is based is the Science of Classical Homeopathy, as defined in the Fifth and Sixth Editions of Samuel Hahnemann's Organon of Medicine
- Education, Training, and Professional Experience (See following)

Certifications

Certified in Homepathy (CHP), American University of Complimentary Medicine

Certified in Clinical Nutrition (CN), Natural Healing Institute

Massage Therapist (LMT), Lincoln Institute of Massage Therapy

I hereby accept full responsibility for any actions taken by myself concerning any foods, homeopathic remedies, herbs, supplements, exercises, and educational therapies with Keverne Collison. I hereby release Keverne Collison from any liability resulting in any possible damages or loss during our association.

Initials: _____ Date: _____

I understand that rather than medical advice or treatment, I am seeking alternative treatment in the form of lifestyle, educational, nutritional, and homeopathic advice and/or recommendations. Under no circumstances, should any suggestions be taken as a diagnosis or direction against the advice of a licensed physical or medical care professional.

I confirm that I am seeking advice in natural health or educational matters only, and if I desire a diagnosis or treatment for any medical condition, I must consult a Physician. I acknowledge that Keverne Collison is not a medical institution, medical doctor or licensed practitioner in the State of California.

I acknowledge that I have read and understood all that is disclosed here.

Name (Print Clearly) _____

Signature _____ Date _____/_____/_____