WELCOME

Our office is an Expression of Vibrational Healing
& Vibrant Wellness

We recognize that as we integrate and wake-up in our bodies,
exposure to certain chemicals in our environment may be harmful
to our systems. We please ask that you refrain from wearing
colognes, perfumes, body lotions & sprays or lacquers
of any kind that give off strong smells and odors
when visiting our office.

****

Please turn all cell phones off before entering.

****

Please enter Entrainment Room "quietly" to allow everyone
present to have their sacred experience without disrupting
noise while placing personal items in baskets under table.

****

Welcome to Transforming your Life…
Achieving levels of Vitality you didn't know were possible.
It is a Joy to have you participate in our practice.

****

Sincerely…Dr. Michael Whelan's Office

Michael Whelan, D.C.

Network Spinal Analysis

Dear Practice Member,

Welcome to our office and thank you for considering us in your quest for optimal health. Nearly everyone wants a healthier body and a better quality of life, it is the direction of our culture. We look forward to working with you on this journey of discovery and glowing health.

Our work with thousands of Practice Members has shown us the following:

- Healthy people with great lives have spines that are softer and more flexible than people who are experiencing illness or disease. Healthy people also breathe more.

- We do not have to be forceful; we can provide gentle care that creates life changing results.

- No matter what else we do for ourselves (diet, exercise, drugs, meditation, etc.) our body and mind can function more effectively when there is less tension in our nervous system and a clearer brain/body connection.

Attached you will find these documents:

- Statement of Purpose
- Health History
- Insurance and Informed Consent

Please read and complete this information prior to your initial visit. We look forward to meeting you.

Warmest Regards,

Michael Whelan, D.C.

Michael Whelan, D.C, 24953 Paseo De Valencia, Suite 12C, Laguna Hills, CA 92653, (949) 581-5231
www.drmichaelwhelan.com

Michael Whelan, D.C.

Network Spinal Analysis

Statement of Purpose

The purpose in sharing this statement of clinical objectives is to clearly define our approach to health, healing and those we serve in this office. We wish to clearly communicate our responsibilities in this exciting relationship.

The following concepts are central to the way in which we care for others. We are pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

- There is intelligence within each individual which not only keeps that person alive, but also coordinates repairs, renews and heals every cell of the body.
- The nervous system is the main distribution center and coordinating system for this intelligence. Proper coordination, repair, movement, healing and genetic potential cannot be fully expressed when this life power and intelligence is suppressed.
- The purpose of the entrainments given in this office are to clear the nervous system of interference, creating greater communication between your mind, body and life, thus promoting better health, vitality and sense of wellbeing. Everyone, in spite of specific symptoms or ailments, can benefit from more vitality and enhanced wellness.
- Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change. This is central to how we care for others. If you want to become healthier and use your symptoms to motivate change in behavior, you are in the right place!
- 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 required for advancement in care.
- Please have a good relationship with your medical doctor. We will not venture into the practice of medicine by advising about the need for reduction of medications. We suggest you speak with your physician to determine the objectives and goals 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.

Consistent with the above concepts, we entrain people’s nervous systems and care for people using the techniques we believe to be the most honoring and effective.

Sincerely,

Dr. Michael Whelan

I, ____, have read this statement of purpose and understand its contents. I understand that the care offered in this office is not a replacement for any form of treatment provided by other types of practitioners. This office offers *Network Spinal Analysis*, *Somato Respiratory Integration*, *Zero Balancing* and *specific chiropractic adjustments* to promote the natural mechanisms for self-healing and empowerment.

Signature:____ Date:________________________________

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Health History

Name____Date _________________

Address____City___________________Zip Code__________________

Phone (H)__________________(O)__________________(C)________________Referred By___________________

Date of Birth_______________Age________Height__________Weight__________eMail_____________________

<u>Your Health Concerns</u>

1. Do you have any current health concerns? If so, please describe:_____________________________________
   ____
2. When did this situation or concern begin?____
3. Have you ever been hospitalized? Yes No
   If yes, for what reason?____
4. Have you had surgery?____
5. Do you still have all your body parts?____
6. Have you consulted a physician or any other health care provider in the past three months? Yes No
7. What is/was the reason for the visit(s)?____
8. What was done or suggested?____
9. Please list drugs, when prescribed and reasons for taking them._______________________________________
   ____
10. Do you have an exercise, meditation, prayer, nutritional or dietary program? Yes No
    Please Explain____
11. Have you ever injured your spine (neck, head, back, hips)? Yes No
    A. Date of most significant injury:____
    B. What happened?____
    C. Date of most recent injury____
    D. What happened?____
12. Have you broken any bones or significantly sprained part of your body? Yes No
    Please Explain____
13. How much confidence do you have in your body's ability to heal itself 1-10_____________________________
14. To what age do you want to live?____

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15. How much do you value your health?____
16. When stressed, how do you "center yourself" or "re-group"?____
17. Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel better about yourself?____
18. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your opportunity for full glowing health?____
19. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge, or add to your health?____
20. How do you rate your physical health?

    Excellent Good Fair Poor Getting Better Getting Worse

21. How do you rate your emotional/mental health?

    Excellent Good Fair Poor Getting Better Getting Worse

22. If you consider yourself ill, why do you feel you are ill?____

    ____
23. If you consider yourself well, why do you feel you are well?____

    ____
24. What are some of your healthy sources of energy?____
25. Where do you get energy that does not really serve you, or is actually unhealthy?_________________________

    ____
26. Are you addicted to anything? (alcohol, sugar, caffeine, adrenalin, etc.)___________________________________
27. What is the main purpose of your visit today?____
28. How will you know when your reasons or goals for being at this office have been met?_____________________

    ____
29. What consumes your time that does not give you a wonderful present or future?_________________________

    ____
30. Is there anything else you wish to share that may help us to better understand you and why you have chosen to be seen by Dr. Whelan?____

Thank you for considering the services offered by Dr. Whelan. We look forward to assisting you on your journey of health, wellness and an enriched life.

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SOCIAL HISTORY

Personal Habits (Please List Current or Past Use, Frequency, and Quantity):

Tobacco: ________________ Caffeine: ________________ Alcohol: ________________ Recreational Drugs: ___________

EXERCISE: List Type of Activities: ________________________________ Frequency per week: ________________

REVIEW OF SYSTEMS (please circle if you are experiencing any of the following symptoms):

Hematologic:
Anemia
Blood diseases
Fatigue, Dizziness
Bleeding/bruising
Blood clots
Skin/Nails:
Skin rash/hives
Brittle Nails
HEENT:
Headaches
Hearing loss
Ringing in the ears
Eye pain/Itchy eyes
Sore throat/allergies
Sneezing/runny nose
Nosebleeds
Sinusitis/allergies
Jaw pain(TMJ)
Mouth/tongue sores
Catches colds easily

Gastrointestinal:
Bad breath
Constipation
Heartburn/ Ulcers
Hepatitis/Jaundice
Diarrhea
Nausea, Vomiting
Bitter taste in mouth
Rectal itching
Hemorrhoids
Burping
Gas/Bloating
Cramping
Laxative use
Blood in stools
Frequency of BM______
Consistency of stool______
Musculoskeletal:
Difficulty walking
Muscular pain/weakness
Joint pain/stiffiness

Cardiovascular:
Stroke
Nosebleeds
Varicose veins
High/Low blood pressure
Chest pain
Heart Disease
Irregular heart beat
Swelling/edema
Cold hands/feet
Varicose veins
Neuro-psychiatric:
Tingling, numbness
Weakness
Eating disorder
Seizures
Paralysis
Poor balance
Poor memory
Poor concentration
Depression, anxiety

Genitourinary:
Kidney Infection,/UTI
KD disease/Stones/Blood in urine
Frequent/night time urination
Incontinence
Frequent, night time urination
Testicular pain/mass
Prostate problem
Sexual dysfunction
STD__________
Systemic Review:
Hot flashes
Excessive sweating
Excessive thirst
Fever/chills
Respiratory:
Tuberculosis
Asthma/wheezing
Difficulty breathing
Cough
Pneumonia

Gynecological:
Menopause
Breast lump/discharge
PMS
Age period started:______
LMP________________
Periods last______days
Periods come every____days
Pain with periods
Heavy menstrual bleeding
No. of pregnancies________
No. of children________
No. of miscarriages________
No. of abortions________
Vaginal discharge/itching
Currently pregnant? Yes/No
Endocrine:
Hair loss/thinning
Dry skin
Hormone therapy

Sleep: Hours/night: ________________ Bedtime: ________________ Waketime: ________________

Do you have problems with: T Staying asleep T Falling asleep T Other sleep issues________________

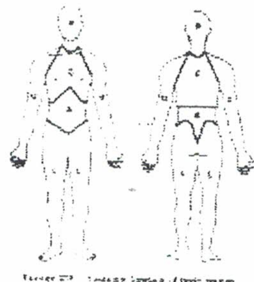
Do you wake up at night? If yes, how often and at what times does this happen? ________________

Energy level (average per week, circle one): (lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress level (average per week, circle one): (lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

Sources of stress: ________________________ How do you cope with stress? ________________

Pain Scale (circle areas and level of pain): (lowest pain) 1 2 3 4 5 6 7 8 9 10 (highest pain)



Please check all that apply: Pain is: T Dull T Sharp

Diet History (include any liquids, tea, coffee, etc.):

Breakfast yesterday: ________________________ AM Snack foods: ________________

Lunch yesterday: ________________________ PM Snack foods: ________________

Dinner yesterday: ________________________ Late PM Snack foods: ________________

Bars/Shakes: ________________________ Glasses or Ounces of plain water intake/day: __________

Please List Any Dietary Restrictions: ____

What level of change to your living habits are you willing to make to improve your overall well-being?

T Whatever It Takes T Significant Change T Some Change T No Change

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Insurance Assignment & Release of Information and Authorization

I, the undersigned, certify that I (or my dependent(s)) have insurance coverage and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. If my insurance requires a referral and I receive care without proper authorization, I understand I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of my benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as valid as the original.

____ _____________________________________

Patient/Guardian Signature Date

Notice of Privacy Practices for Protected Health Information

I acknowledge that my doctor acts in strict accordance with Federal Privacy Regulations (HIPPA) and that I may request my own copy of the doctor's Notice of Privacy Practices for Protected Health Information at any time.

____ _____________________________________

Patient/Guardian Signature Date

Informed Consent for Examination and Treatment

I request and consent to the performance of physical examination and treatment on me or the patient names below for whom I am responsible by any licensed doctors or authorized providers in the office.

____

Print Patient(s) Names

____ _____________________________________

Patient/Guardian Signature Date

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