

# Welcome to Abundant Life Chiropractic

Dr. Eric Harter

Please Print Clearly and Fill In Completely:

Full Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Health History:

Give reason for seeking chiropractic care: \_\_\_\_\_

Describe any health problems, including how long you've had them: \_\_\_\_\_

Are you under the care of any other doctor? Yes  No  If yes, the conditions being treated for: \_\_\_\_\_

List any current medications: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

List any x-rays you've had in the past 2 years: \_\_\_\_\_

## Personal & Family History:

Your Occupation: \_\_\_\_\_ Work Duties: \_\_\_\_\_

Spouse's health status: \_\_\_\_\_

Children's ages and health status: \_\_\_\_\_

## Chiropractic History:

Have you ever been to a Chiropractor before? Yes  No  If yes, Doctor's Name \_\_\_\_\_

Date of last chiropractic visit: \_\_\_\_\_ Reason for care: \_\_\_\_\_

Date of last chiropractic x-rays: \_\_\_\_\_ How long were you under care? \_\_\_\_\_

## Wellness Commitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, Please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Where did you hear about our clinic, or who referred you? \_\_\_\_\_

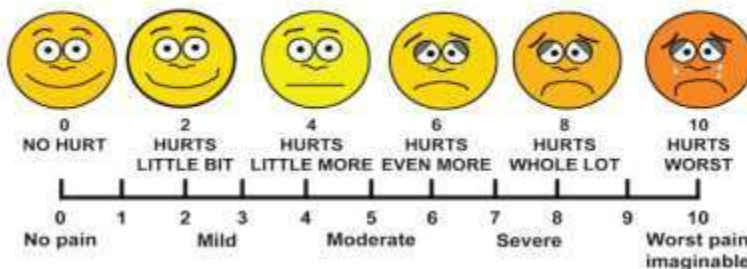
**FEMALES:** Please Check One  Is there a possibility of you being pregnant? Yes  No

*If you have had the following or if you suffer from the following...*

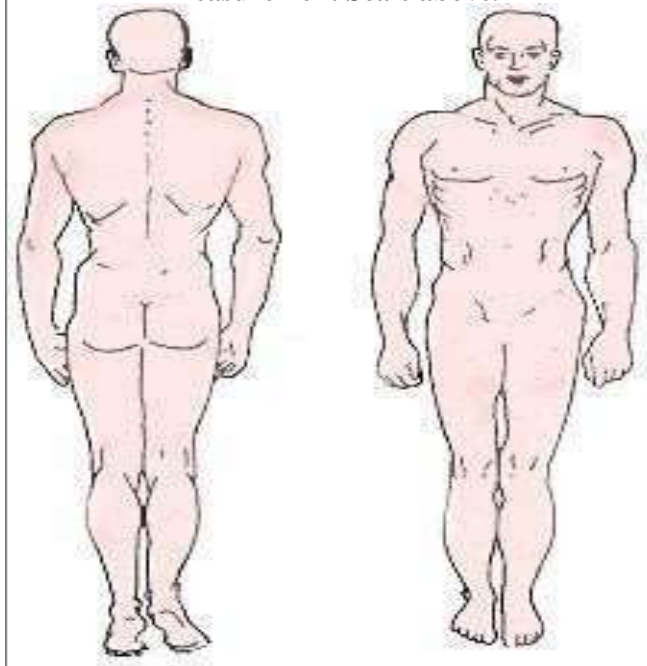
**Please Check:**

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**PAIN MEASUREMENT SCALE**



**Circle the areas where you have any problems. Please also scale these problems using the Pain Measurement Scale above.**



**Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.**

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*Thank you for being complete and thorough.*

**Your Signature Below Please:**

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**Date:** \_\_\_\_\_

# Abundant Life Chiropractic

Dr. Eric L Harter D.C.

1611 Santa Barbara Blvd Suite 170 Cape Coral, FL 33991

Tel: (239)772-2266 Fax: (239)772-1017

Tax ID 46-3575757

**Patient Name:**

**Assignment Of Insurance Benefits:**

I hereby authorize payment to be made directly to **DR. ERIC L HARTER LLC**. of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to **DR. ERIC L HARTER LLC**.

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **DR. ERIC L HARTER LLC**. The rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by **DR. ERIC L HARTER LLC**.

**Authorization To Release Medical Record Information:**

**DR. ERIC L HARTER LLC**. Is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment or services rendered by **DR. ERIC L HARTER LLC**. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said **DR. ERIC L HARTER LLC**.

The undersigned certifies that He / She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of witness:

Date:

Signature of patient or responsible party:

Date:

# ABUNDANT LIFE CHIROPRACTIC INFORMED CONSENT FORM

Dr. Eric L Harter  
1611 Santa Barbara Blvd. Suite 170 Cape Coral, FL 33991  
Tel: (239) 772-2266 Fax: (239) 772-1017

**I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me** (or on the patient

named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic 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, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature:

Date:

Witness Signature:

Date: