McAnsh LIFE-ENERGY Institute
2685 US Hwy 23 South Alpena, MI 49707
(989) 356-9355

*Please **Print** Your Responses in Ink Only!*

General Information

Today's Date: _____ *(XX/XX/XXXX)*

Legal Name: _____ *(First)* *(Middle)* *(Last)* **Birth Date:** _____ *(XX/XX/XXXX)*

How did you find out about us? Age:

Who?

E-mail: **Blood Type:** **O** **A** **B** **AB**

Address: # of Children:

Apt/Suite: City/Town: Marital Status: S M D W

State: Zip: Home Phone:

Employer: Cell Phone:

Occupation: Work Phone:

Health Information

Name of Medical Practitioner: Date of Last Visit:

Reason for Last Visit:

Name of Previous Chiropractors:

Did you follow through with their recommendations?: Y N **Why or why not?:**

Please list all "**Major Life Events**" that you have experienced during the past year (sickness or death of a loved one, change of job, in relationships, of address, stress with children/grandchildren, etc.):

Please List ALL previous **injuries, accidents**, falls, bumps, jars, etc. (with Month & or Year):

Please list ALL **Drugs** (Medications) you are **currently** taking, including **OTC** (**O**ver-**t**he-**C**ounter):

Have you taken the time to look up the side effects of all your medications?: Y N

Please list ALL **Allergies**:

Please list ALL **Surgeries** with dates:

Current Health Status	Yes	No	Location and Description
Any areas of infection, cuts or open skin?	Y	N	
Any areas of swelling, edema or tendency to swell?	Y	N	
Any areas of numbness or altered sensation?	Y	N	
Any areas of pain or tenderness?	Y	N	
Arthritis?	Y	N	
Cancer or Tumors?	Y	N	
Cardiovascular Disease?	Y	N	
Diabetes?	Y	N	
Injuries?	Y	N	
Kidney, Liver or Urinary Problems?	Y	N	
Respiratory Conditions?	Y	N	
Skin Conditions?	Y	N	

Other:

Other Details

Please check ALL areas in which you hope to enhance the quality of life:

- ☐ **Physical Health** (via better body function vs. feelings/symptoms, etc.)
- ☐ **Mental/Emotional Health** (via better sleep, better attitudes, etc.)
- ☐ **Sports/Hobbie**s (via better hand/eye coordination, balance, strength, speed, endurance, etc)
- ☐ **Relationships** (via more energy, better moods, more patience, etc.)
- ☐ **Job/Career** (via clearer thinking, better ideas, more endurance, etc)
- ☐ **School** (via better intelligence, concentration, focus, etc.)
- ☐ **Other:**

What have you tried that <u>hasn't</u> help increase the quality of your life? (check all that apply)

☐ Traditional ("Full-Spine") Chiropractic Care	☐ Positive Thinking	☐ Yoga
☐ Meditation	☐ Prayer	☐ Ice
☐ Visualization	☐ Stretching	☐ Heat
☐ Prescription Drugs	☐ Exercising	☐ Topical Lotions
☐ Physical Therapy	☐ Surgery	☐ Radiation
☐ Over-The-Counter Medications	Other:	

On a scale of 0 (no stress) to 10 (high levels of stress), please indicate the amount of **stress** in your life:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Personal Nutrition

Please list ALL **Nutritional Supplements** (vitamins, minerals, herbs, etc.):

Does your body tend to "**react**" strongly to certain foods, drugs, vitamins, etc.?

Please describe your **Exercise** Program/Routine:

Please describe your **Diet**:

How many grams of **FIBER** do you eat each day?:

Please answer the following questions with your current AVERAGE. Circle your answers i.e. day or week and the type(s).

Alcohol: per day / week?	_____oz.	**Type:**	Beer	White Wine	Red Wine	Distilled Liquor	
Water intake per day?	_____oz.	**Type:**	city	bottled	well	filtered	distilled
Caffeine intake per day?	_____oz.	**Type:**	Coffee	Tea	*Black*	*Green*	Pop:
How much **Tobacco** do you smoke per day / week?			Cigarettes	Pipes	Cigars		

Blood Pressure	Low	Normal	High	Do you wear **heal lifts of insoles**?	Y	N
Blood Sugar	Low	Normal	High	If so, are they the same thickness?	Y	N
How many **meals** do you eat?				Do you wear dentures/other dental appliances?	Y	N
At what times of day?				Do you spend time in tanning booth/sun?	Y	N

How long do you think it will take you to improve the quality of your life?:

___ Weeks? ___ Months? ___Years?

Client Name: _____Reviewed by:_____

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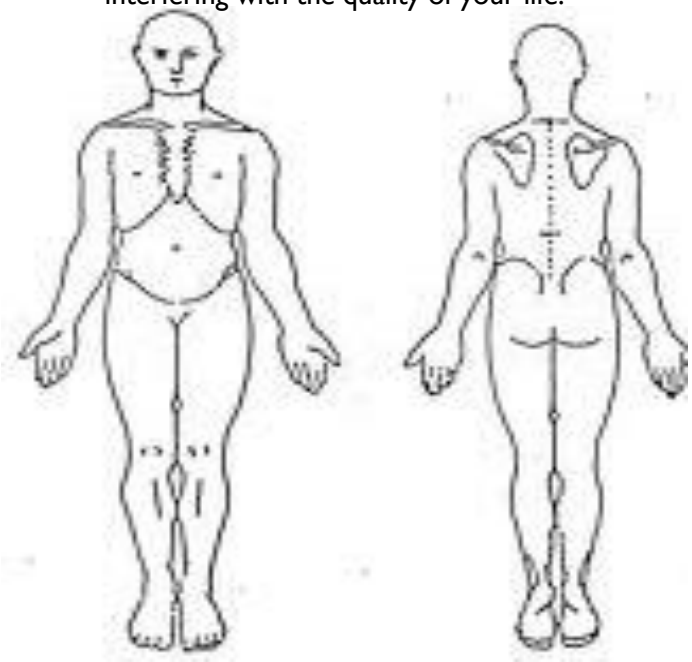
Brain- STEM Awareness Self-Assessment

Please circle Yes (Y) or No (N) as it pertains to each question. Do you:		
1. Feel the need to turn, bend or twist your head in order to get your neck to "pop"?	Y	N
2. Hear or feel the bones in your neck "grinding", "clicking", "popping" or "snapping" when you turn your head from side to side or bend your head toward either shoulder?	Y	N
3. Have a sore jaw joint (TMJ) sometimes more so on one side than the other?	Y	N
4. Feel a nagging ache in your low back (often to one side) that you notice more while lying down?	Y	N
5. Feel more tired, "moody" or stressed than you think you should?	Y	N
6. See in the mirror that your head is tilted more to your left or to your right or too far forward?	Y	N
7. See in the mirror that one shoulder is lower than the other?	Y	N
8. See in the mirror that your pant waist or belt is sitting higher on one side?	Y	N
9. Notice that one "hip" is higher than the other?	Y	N
10. Feel like one leg seems shorter than the other (catch toe on carpet, etc.)?	Y	N
11. Notice that you are not walking evenly?	Y	N
12. See that the bottom of your pant leg is wearing more on side than the other?	Y	N
13. See that the heel of one shoe is wearing more than the other?	Y	N
14. Notice an increase in your symptoms when you cough or sneeze?	Y	N
15. Notice your symptoms worse in the morning and get better slowly as the day goes on?	Y	N

# of Questions Answered "Yes": _____

YOUR Assessment of Your Function

Please indicate on this diagram the areas you feel are interfering with the quality of your life.



Feel free to use X's, lines, circles, arrows, or words. Use whatever helps YOU tell YOUR "story".

IF you have **ONE OR MORE** of the signs above, then you are in need of a a *series* of adjustments in order to enhance the quality of your life by having your subluxations (sub-luck-SAY-shuns) corrected.

The care we provide is NOT considered "Medically Necessary" by Medicare.

Medicare will NOT pay for the care we provide.

Because we do NOT have a legal obligation to bill Medicare for the care we provide, we will NOT bill them for it.

Client Name: _____Reviewed by:_____

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Policy and Consent Statements and Agreements

Financial Policy

I agree to pay in full at the time of service unless I have signed up and paid for a package of care.

1. All clients will be notified of changes in fees (when needed) before their session/service begins.
2. Payment is required immediately before or after services are rendered and **a client may be charged a $25.00 missed appointment fee** for any missed appointments without more than **4 hours advanced notice**. If the client is late for their scheduled massage time, the fee of the scheduled massage will be charged but the client may only receive massage during the remaining time previously scheduled.
3. **ML-Ei does NOT process claims from Medicare, Medicaid, Auto Insurance, Personal Injury or Worker's Compensation. We do NOT bill for these claims. I agree that the reason for my visits is NOT a result of these types of claims.**
4. I agree to pay ML-Ei $22.50 "Return Check Fee" for any and all checks that do not clear the bank.

Initial here if you have read and agreed to the above statements: _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosures for the purposes of care, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

In the future, we may contact you for appointment reminders, announcements and to inform you about our practice.
I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

_____

Print Name *Signature* *(Relationship to Client)* *Date*

_____ _____

Client Name if not listed above *Institute Signature* *Date*

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Terms of Acceptance & Informed Consent

The following statements relate to **all** of the services offered by ML-Ei. Note that some of the statements may list particular services and this may or may not include the other services offered.

I understand that I am informed and agree to the following statements:

1. **The chiropractic care plans that we offer include chiropractic adjustments for the purpose of enhancing the quality of life which is supportive in nature, considered chiropractic maintenance therapy which is NOT covered by Medicare and MAY NOT be covered by your commercial health insurance, HSA, MSA or FSA.**
2. It is the client's responsibility to keep the service provider informed of ALL medical treatments and/or conditions. Written permission from your medical physician may be required in the instances of contraindications.
3. If you wish to end your massage session at any point during the, please indicate that to your Massage Therapist.
4. The massage therapist does **not** work within the parameters of a licensed **medical** professional and the massage therapist does not diagnose nor treat diseases. Within the scope of teaching and facilitating, the massage therapist **may** suggest exercise, lifestyle and/or water intake advice. Clients are free to follow or avoid any advice.
5. Some insurance companies will cover massage or chiropractic therapy when referred by a doctor. ML-Ei will follow the correct procedures in billing these services but there is no guarantee that the services will be paid by my insurance company. If no payment is received, I agree to pay for all services in full. I understand that nutrition services are NOT COVERED by ANY insurance and that fees are due and payable at time of purchase or service.
6. **Sexual advances of any kind will not be tolerated and the session will end immediately. The fee for the session will not be refunded or pro-rated**.
7. Nutrition services include nutritional analysis, evaluations, consultations and/or recommendations. I understand and am informed that those services and the nutritional supplements and/or foods offered for sale by the health practitioner and/or his/her staff are specific to the organs, glands and systems of the human body and are not intended to diagnose, treat or prevent any symptoms or disease.
8. The products and services that have been recommended are traditionally and historically considered safe. Some nutritional supplements may be toxic in high dosages which we do not recommended. Some nutritional supplements may be inappropriate during pregnancy. I will notify the health practitioner and/or his/her staff if I am or become pregnant.
9. I agree to stop using any nutritional supplements and inform the health practitioner and/or his/her staff if I experience any gastrointestinal upset (including but not limited to nausea, gas, stomachache, vomiting), allergic reactions (including but not limited to hives, rashes, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, recommended by the health practitioner and/or his/her staff.____

Initial here if you have read and agreed to the above statements: _____

Standard Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium.

This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed

by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement.

The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____ as effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

I have read and understand this information. Any questions that I had have been answered to my satisfaction be the ML-Ei staff. . All medical conditions I am aware of have been disclosed and/or discussed with ML-Ei. By signing below, I certify that the information above is complete to the best of my knowledge and I agree to participate in services offered at McAnsh LIFE-ENERGY Institute.

Print Name	*Signature*	*(Relationship to Client)*	*Date*

Client Name if not listed above	*Institute Signature*	*Date*