WOLLEN WELLNESS & CHIROPRACTIC
A PROACTIVE APPROACH TO HEALTH CARE
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TERMS OF ACCEPTANCE

When a patient seeks chiropractic/nutritional health care and we accept a patient for such care, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation or a nutritional deficiency. However, if during the course of a chiropractic/nutritional spinal examination, we encounter non-chiropractic/nutritional or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the appropriate health care provider. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's fullest potential. Our only method is specific adjusting to correct vertebral subluxations and nutritional recommendations.

I, _____ have read and fully understand the above statements.
Print name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic and/or Nutritional care on this basis.

_____ _____
Signature *Date*

Consent to evaluate and adjust a minor child

I, _____ being parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature *Date*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
Signature *Date*