DR. DICK SHEPARD
"not your ordinary chiropractor"

(206) 525-4155

8301 - 8th Ave NW
Seattle, WA 98117

Personal History

Name:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ Occupation:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address:_____*(to receive our informative Newsletters & healing tips)*

D.O.B. _____ Age:_____ ☐ M ☐ F Marital Status:_____ No. Children: _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS SO THAT WE MAY SERVE YOU BETTER.

1. How did you hear about our office?_____

2 Have you had, or do you receive any of the following for health, wellness, personal growth?
If yes, add any comments you wish to share.

Chiropractic: ☐Yes ☐No _____

Bodywork/massage: ☐Yes ☐No _____

Osteopathy/Cranial Work: ☐Yes ☐No _____

Meditation: ☐Yes ☐No _____

Psychotherapy: ☐Yes ☐No _____

Movement/Exercise: ☐Yes ☐No _____

Yoga: ☐Yes ☐No _____ Prayer: ☐Yes ☐No _____

Rebirthing/Breathwork ☐Yes ☐No _____ Other: _____

Acupuncture: ☐Yes ☐No _____

Network Care: ☐Yes ☐No, When_____ Where_____ Who_____

3 What do you hope to receive from wellness care at this office? _____

_____

_____

_____

_____

The work practiced in this office is based on stresses that have accumulated over your lifetime that your body has been unable to properly perceive, adapt to, and/or recover from. These stresses include PHYSICAL, CHEMICAL, and EMOTIONAL STRESSES.

PHYSICAL STRESS - **BIRTH STRESS**: If you have information about your birth history:

1 Was your mother outwardly ill prior to her pregnancy with you? ☐Yes ☐No

2 Did your mother have a difficult pregnancy with you? ☐Yes ☐No

3 Did your mother have any falls, accidents, or injuries during pregnancy? ☐Yes ☐No

4 Was your birth traumatic? ☐Yes ☐No

5 Was your birth:

☐ Drug Induced	☐ Forceps or Suction
☐ C-Section	☐ Cord around the neck
☐ Breech	☐ Prolonged
☐ Natural	☐ Other:_____

6 Describe any other physical or mechanical stress to your mother or you as labor and delivery progressed, or as a newborn: ☐Yes ☐No _____

GENERAL PHYSICAL STRESSES:

7 Next to each stress/trauma are check boxes. Please check the appropriate box - P for past, C for current, and the appropriate level of stress: Mild, Moderate, or Extreme.

	Mild		Moderate		Extreme			Mild		Moderate		Extreme	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib/carriage	☐	☐	☐	☐	☐	☐	Sports impacts	☐	☐	☐	☐	☐	☐
Falls up/down stairs	☐	☐	☐	☐	☐	☐	Physical fights	☐	☐	☐	☐	☐	☐
Falls on ice	☐	☐	☐	☐	☐	☐	Armed services	☐	☐	☐	☐	☐	☐

Comments:_____

8 Have you ever been knocked unconscious? ☐Yes ☐No

Comments:_____

9 Have you ever broken any bones? ☐Yes ☐No

Comments:_____

10 Have you ever had any impacts, falls, or jolts that you felt specifically may have injured your spine? ☐Yes ☐No Comments:_____

11 Have you had extensive dental work performed? ☐Yes ☐No

Orthodontial work? ☐Yes ☐No

SPORTS and LEISURE ACTIVITIES:

12 Have you ever been hurt or injured during any sports activities? ☐Yes ☐No

Comments:_____

13 Do you sit at a computer for long periods (for work or play)? ☐Yes ☐No

14 Do you wear: glasses ☐ Bifocals ☐ Contact lenses ☐

AUTO ACCIDENTS:

15 Have you ever been involved in any vehicular accident or near accident ? (please list all, even if you think you were not hurt or were a passenger)

Automobile:_____

_____

_____

Bus, bicycle, motorcycle, train, airplane, motor scooter, or other vehicle: _____

_____

_____

MEDICAL TREATMENT:

16 Have you ever been hospitalized? ☐Yes ☐No

If yes, what was actually done to you? _____

_____

_____

Have you had surgery? (If yes, please describe)_____

Do you still have all your body parts? _____

Have you had: a spinal tap ☐ spinal injections ☐ physiotherapy ☐ neck collar ☐ spinal brace ☐ traction ☐ heel lifts ☐ x-ray treatments ☐ corrective shoes or bars ☐ extensive diagnostic x-rays ☐ chemotherapy ☐ transfusion ☐ bone in a cast or immobilized ☐

CHEMICAL STRESS

BIRTH HISTORY

1 Was your mother regularly taking any drug prior to or during her pregnancy with you?

Alcohol ☐ Smoking ☐ Other ☐ _____

2 Was her labor chemically induced or altered? ☐Yes ☐No

3 Was your mother: conscious ☐ semi-conscious ☐ unconscious ☐ , during your delivery?

4 Any other chemical stress your mother may have been subject to:_____

_____

_____

GENERAL CHEMICAL STRESSES

5 Are you now taking any drug (prescription, over the counter, or recreational) regularly? Please list:

_____

_____

Are any being prescribed by a physician? ☐Yes ☐No Last visit: _____

6 Were you previously taking any medication or drug (of any type) regularly? ☐Yes ☐No

Comments:_____

7 Do you work, or have you worked, with any chemical, fume, dust, powder, smoke, solvent, etc. for prolonged periods? If yes, please describe._____

_____

8 Please complete the stress list below:

Number of organs removed		No. of steroid type drugs used in the past year	
No. of synthetic drugs used currently		Level of personal stress (1-10)	
No. of tobacco products used a day		No. of sugar products used in a day	
No. of street drugs used each month		No. of alcoholic drinks in a day (average)	
No. of caffeine products per day -- (coffee, tea, soda, etc.)		No. of unresolved emotional factors -- (fear, anger, depression, anxiety, etc)**	

** List major only. Generally between 3 and 6.

EMOTIONAL STRESS

BIRTH HISTORY

1 My birth was: at home ☐ in a birthing center ☐ in a hospital ☐

2 Were you incubated or isolated after birth? _____

3 Were you: bottle fed formula ☐ bottle fed mother's milk ☐ nursed ☐ nursed and bottle fed ☐

GENERAL EMOTIONAL STRESSES

With each of the following stresses, please check the appropriate box - P for past, C for current, and the appropriate level of stress: Mild, Moderate, or Extreme.

	Mild		Moderate		Extreme			Mild		Moderate		Extreme	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood Stress	☐	☐	☐	☐	☐	☐	Work Related Stress	☐	☐	☐	☐	☐	☐
School Stress	☐	☐	☐	☐	☐	☐	Stress of Commuting	☐	☐	☐	☐	☐	☐
Play/Recreational	☐	☐	☐	☐	☐	☐	Loss of Loved One	☐	☐	☐	☐	☐	☐
Family Stress	☐	☐	☐	☐	☐	☐	Change in Lifestyle	☐	☐	☐	☐	☐	☐
Personal Relationships	☐	☐	☐	☐	☐	☐	Change in Vocation	☐	☐	☐	☐	☐	☐
Stress of Being Sick	☐	☐	☐	☐	☐	☐	Abuse	☐	☐	☐	☐	☐	☐

4 How do you grade your physical health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse ☐

5 How do you grade your emotional/mental health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse ☐

6 If you consider yourself ill, why do you feel you are ill? _____

_____

_____

_____

7 If you consider yourself well, why do you consider yourself well? _____

_____

_____

_____

8 Is there anything else you may wish to share which may help us to better understand you, why you have chosen to come to our office, and what you hope to receive here? _____

_____

_____

_____

_____

_____

_____

Thank you for providing this information so we may serve you to our best ability!

DOCTOR'S COMMENTS - Please Do Not Write in this Box.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dr. Dick Shepard

"not your ordinary chiropractor!"

Informed Consent Form

The following pages MUST be read, filled out & signed in order to receive care at this office.

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor who provides Network Care and other clinical techniques, low force approaches which have unique outcomes and clinical results. This practitioner chooses to practice this and has been trained extensively and certified in these procedures, and he is professionally and personally confident in regard to the safety and effectiveness of this care.

The purpose of this consent form is to help you better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

Dr. Shepard does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and, specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.***

Network consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal) training. There is also a body of research characterizing Network care and documenting its unique and significant wellness benefits.

I am aware that I will be receiving gentle touch Network adjustments, also called ***entrainments***. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. These will occur when needed or requested. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

There is a progression of care which involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, the redistribution of energy, and increased transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to regular adjustments / entrainments, my practitioner may perform additional exams or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension.

It is common for people receiving this care to breathe more deeply and fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to 'bust' stress, and to experience more of their inner energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, and experience of the body-mind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

I have read this consent form and ***understand that the care in this office is <u>different</u> from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care at this office, which consists of, or includes Network Care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.***

_____ _____

PRINT YOUR NAME DATE

X_____

SIGN YOUR NAME

Scheduling and Payment Procedures

First Visit	***$150*** *(includes consultation, exam, and entrainment)*
Entrainment	***$52***
Child 0 to 9	***$20*/ $52*** ***** with Parent under Regular Care*
Child 10 - 15	***$30* / $52*** ***** with Parent under Regular Care*
Re:Eval/Consult	***$100***

Payment -

All services are to be paid at the time of the service. *There will be a $10.00 service fee for late payment or if we have to bill you. A $25.00 fee for a second copy of Superbills already given and a $50.00 or more fee to fax or copy chart notes.*

Arrival Procedures - - ***Please arrive five to ten minutes before your scheduled appointment .*** *This gives you enough time to be prepared to walk into the entrainment room, ready to get on a table at your scheduled time. We want to respect everyone's busy schedule and these policies help things run more smoothly for everyone.*

Cancellation/ Rescheduling - *For everyone's convenience, twenty-four hours notice of rescheduling or cancellation of appointments is required. Cancellations or reschedules made less than 24 hours in advance will be charged the full rate for the appointment(s) booked. Also, if you are late for your appointment, you will forfeit the appointment and be charged the full rate.*

Insurance and Superbills - *We do not bill insurance directly. We will provide, on request, a monthly superbill for you to send to your insurance company for reimbursement. We do not provide chart notes, letters to insurance companies, or referrals to other providers. (There will be a charge for chart notes & specialized superbills requested beyond monthly ones.)*

Medicare / Medicaid - Sorry. We do not accept Medicare or Medicaid. *If you are eligible for Medicare/Medicaid, we can accept you for care on a cash basis only (i.e., no superbills, no insurance reimbursement forms).*

By signing below I acknowledge that I have read and understand the above policies.

Signed X_____ *Print Name* _____*Date*_____

DR. DICK SHEPARD

"not your ordinary chiropractor"

Cancellation Policy:

You must fill out and sign this form to receive care at this office!

When you schedule an appointment, we reserve this time especially for you. As a courtesy to everyone, please remember:

24 Hour Notice: If you need to cancel or change your appointment, please do so at least 24 hours before your scheduled time to avoid any fees. This must be by phone (206-525-4155) or in person, i.e., no emails or texts. If you provide a shorter notice or do not show up, your credit card will be charged the regular session rate for the appointment. If you are ***LATE***, it will be considered a missed appointment and you will owe for that appointment.

(Note: Your card will only be charged if you cancel or reschedule with less than 24 hrs. notice. This cancellation policy applies, regardless of the reason for the cancellation or reschedule.)

By signing below, I acknowledge that I understand and agree to this policy:

Signature: X_____Date:_____

Print Name:_____

Credit Card Information (Visa or MasterCard only)

Card Number: X_____

Expiration Date: X_____ CVV2: X_____

8301 8th Avenue NW • Seattle, Washington 98117

206-525-4155 www.networkcare.org