

DR. DICK SHEPARD

"not your ordinary chiropractor"

History Form Instructions

- Please fill out the following form. (Note: CC #'s will be done at the office.)
- Then you may print it out and bring it with you to your first visit *or*...
- You may email it to us at: networkcare@zipcon.com

Thank you!



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 ou	r informative	Newsletters & healing tips)
D.O.B Age	: □ M	☐ F Marital Sta	tus:	No. Children:
PLEASE ANSWER <u>ALL</u> THE F	FOLLOWING Q	UESTIONS SO 1	THAT WE MA	Y SERVE YOU BETTER.
1. How did you hear about our of	fice?			
2 Have you had, or do you received If yes, add any comments you	-	lowing for health,	, wellness, pe	rsonal growth?
Chiropractic: □Yes □No _				
Bodywork/massage: □Yes	□No			
Osteopathy/Cranial Work:	□Yes □No			
Meditation: □Yes □No				
Psychotherapy: □Yes □No	o			
Movement/Exercise: □Yes	□No			
Yoga: □Yes □No		Prayer: \square	lYes □No	
Rebirthing/Breathwork □Y	es □No		Other:	
Acupuncture: □Yes □No _				
Network Care: □Yes □No	, When	Where	\	Who
3 What do you hope to receive from	om wellness car	e 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 h	have information abou	ut your birth l	nistory:				
1 Was your mother outwar	rdly ill prior to her pregnand	cy with you?	□Yes □No					
2 Did your mother have a	difficult pregnancy with you	u ?	□Yes □No					
3 Did your mother have ar	ny falls, accidents, or injurie	es during pregnancy?	□Yes □No					
4 Was your birth traumation	:?		□Yes □No					
5 Was your birth:	□ Drug Induced	☐ Forceps or Suct	tion					
5 Was your birdin	•	·						
	☐ C-Section	☐ Cord around th	e 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 new	born: □Yes □No							
GENERAL PHYSICAL ST	RESSES:							
7 Next to each stress/trau	ma are check boxes. Please	e check the appropriate	te box - P for	past, C for				
current, and the appropr	riate level of stress: Mild, M	loderate, or Extreme.						
	Mild Moderate Extreme		Mild M	oderate Extreme				
	PC PC PC		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 kno	cked unconscious?			□Yes □No				
Comments:								
9 Have you ever broken ar	ıy bones?			□Yes □No				
Comments:								
10 Have you ever had any	impacts, falls, or jolts that	you felt specifically n	nay have	□Yes □No				
injured your spine? Cor	mments:							
11 Have you had extensive	e dental work performed?			□Yes □No				
Orthodontial work?	Orthodontial work?							

SPORTS and LEISURE ACTIVITIES:

2 Have you ever been hurt or injured during any sports activities?	□Yes □No
Comments:	
3 Do you sit at a computer for long periods (for work or play)?	□Yes □No
4 Do you wear: glasses □ Bifocals □ Contact lenses □	
AUTO ACCIDENTS:	
5 Have you ever been involved in any vehicular accident or near accident ? (pleas	se 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:	
6 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 \square spinal injections \square physiotherapy \square neck collar \square	□ spinal brace □
traction \square heel lifts \square x-ray treatments \square corrective shoes or bars \square extensive	ve diagnostic x-rays □
chemotherapy \square transfusion \square bone in a cast or immobilized \square	
CHEMICAL STRESS	
BIRTH HISTORY	
Was your mother regularly taking any drug prior to or during her pregnancy with	ı you?
Alcohol □ Smoking □ Other □	
Was her labor chemically induced or altered? □Yes □No	
	ır delivery?
Was your mother: $\;$ conscious \square semi-conscious \square unconscious \square , $\;$ during you	il delivery:

$\overline{}$		١		٦ ٨		\sim 1	1 6	- 1	ΛТ	~ 1	N١	\sim	ᇚ		$\overline{}$	$\overline{}$		_
(7	-	N	-	ζД	١L	(1	76	- 17	11	(4	41	S	ıк	-	╮	\neg	т	•

Are any being prescribed by a physician? □Yes □No Last visit:	
6 Were you previously taking any medication or drug (of any type) regularly? \Box Yes \Box N	0
Comments:	
7 Do you work, or have you worked, with any chemical, fume, dust, powder, smoke, soly 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	No. of unresolved emotional factors
(coffee, tea, soda, etc.)	(fear, anger, depression, anxiety, etc)**

^{**} List major only. Generally between 3 and 6.

EMOTIONAL STRESS

DIDT		LITC	r	$\mathbf{D} \mathbf{V}$
BIRT	п	HI2	ΙU	'K Y

1 My birth was: at home \Box	in a birthing center \Box	in a hospital \square	
2 Were you incubated or iso	olated after birth?		
3 Were you: bottle fed form	mula □ bottle fed moth	er's milk \square nursed \square	nursed and bottle fed $\hfill\Box$

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 M	oderate	Extreme		Mild M	oderate	Extreme
	P C	P C	P C		РС	РС	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	\$220	(includes consultation, exam, and entrainment)
Adjustment	\$70	
Non Office Hours	\$130	
Re:Eval/Consult	\$160	

Payment -

All services are to be paid at the time of the service. There is a \$25.00 fee for a second copy of Superbills already given and a \$50.00 or more fee to send and/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 only accept you for care on a cash basis (i.e., no superbills, no insurance reimbursement forms).

Signed X	Print Name	Date

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



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 Inform	ation (Visa or MasterCard only)	
Card Number: X		
Expiration Date: X_		CVV2: X
	PLEASE NOTE: SIGNATURE & C.C. #'s WILL BE	

8301 8th Avenue NW • Seattle, Washington 98117

COLLECTED AT THE OFFICE.