Chase Life CHIROPRACTIC

NEW PATIENT INTAKE FORM

Name: _____

Date of Birth: _____/_____/_____ Age: _____ ▢ Male ▢ Female Today's Date _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____ Email Address:_____

Occupation: _____ Employer: _____ Are you a student? ▢ Yes ▢ No

▢ Single ▢ Married ▢ Divorced ▢ Widowed Spouse's Name: _____ # of Children: _____

Names, Ages, & gender: _____ Pregnant?: ▢ Yes ▢ No

Have you ever been in the military? ▢ Yes ▢ No Who can we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THE OFFICE

	Health Concern: (List according to Severity)	Rate of severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had th problem before? If so, when?	Did this begin with an injury?	Are symptoms Constant (C) Intermittent (I)?
1st:	_____	_____	_____	_____	_____	_____
2nd:	_____	_____	_____	_____	_____	_____
3rd:	_____	_____	_____	_____	_____	_____
4th:	_____	_____	_____	_____	_____	_____

HAVE YOU SEEN OTHER DOCTORS FOR THESE CONDITIONS? ▢ Yes ▢ No

▢ CHIROPRACTOR ▢ MEDICAL DOCTOR ▢ Other: _____

WHO AND WHEN? _____

WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain):

_____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

____ Headaches	____ Epilepsy/Convulsions	____ Sinus Issues	____ Kidney Problems
____ Migraines	____ Tremors	____ Allergies	____ Bladder Problems
____ Neck Pain	____ ADD/ADHD	____ Frequent Colds	____ Bed Wetting
____ Shoulder Pain	____ Sensory & Spectrum	____ Jaw/TMJ Pain	____ Cysts/Endometriosis
____ Arm Pain	____ Anxiety/Nervousness	____ Thyroid Issues	____ Menstrual Problems
____ Hand Pain	____ Depression	____ Heart Problems	____ Prostate Problems
____ Chest Pain	____ Sleep Problems	____ High/Low BP	____ Sexual Dysfunction
____ Upper Back Pain	____ Loss of Energy/Fatigue	____ Difficulty Breathing	____ Infertility
____ Mid Back Pain	____ Focus & Memory Issues	____ Asthma	____ Numb/Tingling in Arms/Hands
____ Lower Back Pain	____ Double/Blurry Vision	____ Stomach Problems	____ Numb/Tingling in Legs/Feet
____ Hip/Leg Pain	____ Ear Infections	____ Nausea	____ Sciatica
____ Knee Pain	____ Hearing Loss	____ GERD/Reflux	____ Arthritis/Joint Pain
____ Foot Pain	____ Ringing in the Ears	____ Digestive Issues	____ Poor Posture
____ Scoliosis	____ Loss of Balance	____ Gastric Ulcers	____ Tight/Sore Muscles
____ Disc Problems	____ Dizziness / Vertigo	____ Diarrhea	____ Sports Injury
____ Fibromyalgia	____ Connective Tissue Disorder	____ Constipation	____ Skin Problems

Other(s):_____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Cancer	___ Seizures	___ Scoliosis	___ Spinal Bone Fracture
___ Heart Attack	___ Stroke	___ Arthritis	___ Spinal Surgery
___ Diabetes	___ Other: _____		

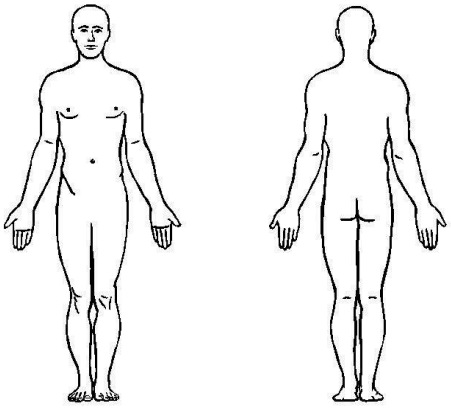
PLEASE MARK the areas on the diagram with the following LETTER(S) to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

When is/are the problem(s) at its worst? AM PM Mid-Day Late PM



List all surgical operations & years:

_____

_____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

List all over the counter & prescription medications you are on, & the reason for each:

_____

_____

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? ▢ Yes ▢ No Fractured A Bone? ▢ Yes ▢ No

If yes to either of the above, please describe:

_____

Other trauma:_____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: **No pain _____ *Back Pain* *Headaches* Worst possible pain**

0 1 2 3 4 (5) 6 (7) 8 9 10

1. How would you rate your pain RIGHT NOW?_____

   0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain? _____

   0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 is your pain at its best?)_____

   0 1 2 3 4 5 6 7 8 9 10

   What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 is your pain at its worst?)

   0 1 2 3 4 5 6 7 8 9 10

   What percentage of your awake hours is your pain at its worst? _____%

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Sit to Stand	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Carry Groceries	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Climbing Stairs	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Pet Care	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Driving	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Extended Computer Use	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Household Chores	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Lifting Children	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Dressing	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sexual Activities	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sleep	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Static Sitting	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Static Standing	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Walking	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Washing/Bathing/Shaving	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sweeping/Vacuuming	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Yard work	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Garbage	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Concentration (Reading)	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Other_____	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform

WHAT ARE YOU HOPING TO ACHIEVE WHILE UNDER CARE?

HEALTH GOAL EXAMPLE: Get rid of my headaches. SIGNIFICANCE OF GOAL: I want to play with my kids without pain.

1. _____ _____

2. _____ _____

3. _____ _____

_____ _____

SIGNATURE DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____
PRINT NAME HERE

_____ _____
PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE DATE

WRITTEN CONSENT FOR A MINOR *IF THIS HEALTH PROFILE IS FOR A MINOR, PLEASE FILL OUT AND SIGN BELOW*

NAME OF PATIENT WHO IS A MINOR/CHILD: _____

I AUTHORIZE DR. CHASE BLAHA AND ANY AND ALL CHASE LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY CHASE LIFE CHIROPRACTIC.

_____ _____
GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD DATE

_____ _____
WITNESS SIGNATURE (OFFICE STAFF) DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
SIGNATURE DATE

Practice Member Information (Must be completed before services can be rendered)

NAME: _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE:_____

NAME OF PRIMARY INSURANCE CARRIER: _____

NAME OF INSURED: _____ INSURED DATE OF BIRTH: _____

INSURED SOCIAL SECURITY NUMBER: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

NAME OF INSURED: _____ INSURED DATE OF BIRTH: _____

INSURED SOCIAL SECURITY NUMBER: _____

INSURANCE POLICIES AND FEE SCHEDULE

- CONSULTATION: INCLUDES PRACTICE MEMBER HISTORY. THIS SERVICE IS COMPLIMENTARY
- ASSESSMENT (NEW OR ESTABLISHED PRACTICE MEMBER): INCLUDES ONE OR MORE OF THE FOLLOWING: THERMOGRAPHY, SURFACE ELECTROMYOGRAPHY, RANGE OF MOTION, MOTION AND/OR STATIC PALPATION, LEG CHECK $50-$75
- CHIROPRACTIC ADJUSTMENT: THE ACTUAL RE-ALIGNMENT OF THE VERTEBRA DONE BY HAND. OFTEN A SOUND WILL BE HEARD BUT IF THERE IS NO AUDITORY RESULT, IT DOES NOT MEAN THE ADJUSTMENT HAS NOT TAKEN PLACE. $40-$60
- XRAYS: SPECIFIC XRAY VIEWS TAKEN OF YOUR SPINE TO BE DETERMINE A MISALIGNMENT/SUBLUXATION OF YOUR VERTEBRAE. THESE CAN ALSO BE USED TO INDICATE PROGRESS AFTER PERIOD OF CARE. $50 PER VIEW

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I AUTHORIZE AND REQUEST PAYMENT OF INSURANCE BENEFITS DIRECTLY TO CHASE BLAHA, DC. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL SERVICES RENDERED UNTIL I REVOKE THE AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THAT IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT AND THAT CHASE LIFE CHIROPRACTIC RESERVES THE RIGHT TO ADD A $25.00 SERVICE CHARGE TO MY ACCOUNT FOR ANY RETURNED CHECK OR CHARGEBACK. I AUTHORIZE THE FACILITY ALONG WITH ANY BILLING SERVICE AND THEIR COLLECTION AGENCY OR ATTORNEY WHO MAY WORK ON THEIR BEHALF, TO CONTACT ME ON MY CELL PHONE AND/OR HOME PHONE USING PRE-RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRONIC MAIL, TEXT MESSAGING OR ANY OTHER FORM OF ELECTRONIC COMMUNICATION.

SIGNED: _____ DATE: _____

TERMS OF ACCEPTANCE

To provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic.

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region, or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic .
G. We invite you to speak frankly to the doctor or any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment .

By my signature below, I have read and fully understand the above statements.

_____ _____
SIGNATURE DATE

MEDIA RELEASE AGREEMENT

I grant permission to Chase Life Chiropractic hereinafter known as the “Media” to use my image (photographs and/or videos) for use in Media publications including: Social Media Posts, Videos, Email Blasts, Education Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use in known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image(s).

Please initial the paragraph below which is applicable to your present situation:

_____ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ I am the parent or guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ _____
PRINT NAME (your name or minor’s name) DATE

_____ _____
SIGNATURE SIGNATURE OF LEGAL GUARDIAN
(under 18 years of age)

X-RAY AUTHORIZATION

Last, First, M: _____

FILE #: _____

DOB: _____

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.
DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR DAY OF OPERATION.
PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS.
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF CHASE LIFE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT NAME HERE DATE OF BIRTH

_____ _____
SIGNATURE DATE

FEMALE PATIENT ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT CHASE LIFE CHIROPRACTIC.

_____ _____
SIGNATURE DATE

---------- *DO NOT WRITE BELOW THIS LINE* ----------

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

Sex: M / F

NOTES:
_____
_____
_____
_____
_____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MHA 300 Size14x17

☐ Lateral Lumbar ☐ R/L Flex

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

CA Initials:
_____

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR REVIEW.

_____ _____

PLEASE PRINT NAME HERE DATE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
HEADACHES					
NECK PAIN					
JAW PAIN/TMJ					
SHOULDER PAIN					
BACK PAIN					
HIP/LEG PAIN					
ARTHRITIS/JOINT PAIN					
EAR INFECTIONS					
HEARING LOSS					
DIZZINESS					
LOSS OF ENERGY					
NERVOUSNESS					
BLURRED/DOUBLE VISION					
ANXIETY					
ADD/ADHD					
DEPRESSION					
ALLERGIES					
SINUS ISSUES					
THYROID PROBLEMS					
ASTHMA					
BREATHING PROBLEMS					
HEART PROBLEMS					
HIGH/LOW BLOOD PRESSURE					
STOMACH PROBLEMS					
BED WETTING					
INFERTILITY					
SCIATICA					
FIBROMYALGIA					
POOR POSTURE					
SLEEP PROBLEMS					
STROKE					
CANCER					
HEART DISEASE					
DIABETES					
ARTHRITIS					
ALZHEIMERS					