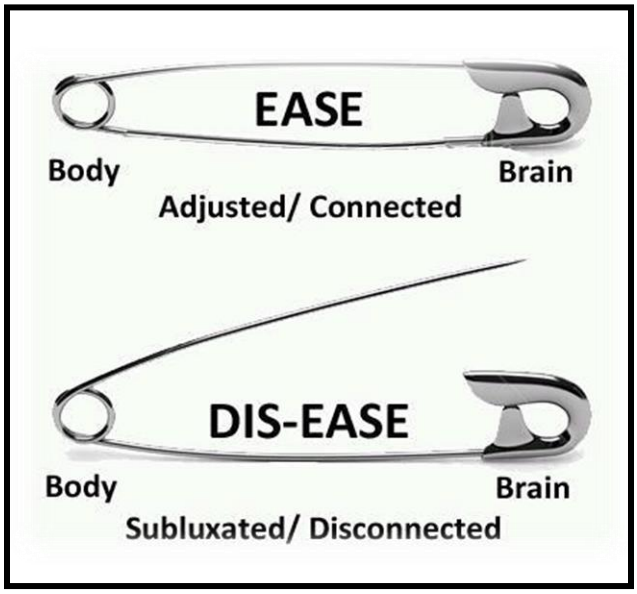
THE SAFETY PIN *Life* SYSTEM



ROCKET CITY CHIROPRACTIC
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THE SAFETY PIN SYSTEM

The SAFETY PIN SYSTEM is a unique approach to **achieving and maintaining optimal health**.

Today in America, the priority in health care is to help people after they are already sick. That is a backwards approach to health care and is why we are getting sicker and sicker. Recently a medical researcher stated plainly, "**We are not living longer we are dying longer."** In other words, we have the capacity to keep people alive for longer and longer durations, but the majority of these people do not have a good quality of life. They cannot do most of the things that would allow them to live fulfilling lives.

Wouldn't it be great if we could work at staying healthy, instead of waiting to get sick? What if we could roll back the biological clock on the average person? What if 50 really was the new 40? Or 60 was the new 50?

What if we could set up a system to allow you to do things at the age of 50, that you thought were impossible to do at the age of 40, or 30 for that matter?

That is exactly what the **SAFETY PIN SYSTEM** is designed to do. We are here to help you live longer and healthier, not die longer!!

How does the **SAFETY PIN SYSTEM** work?

1. HEALTH DANGERS - DISCOVERY

Unique questions will lead to new answers.

We will begin by looking at the current state of your health and wellness. In essence, how are you doing right now? We will also ask you some detailed questions about your history and your family health history.

It is important to understand that your current health problem started years ago and was multi-factorial in origin. The only exception would be an acute trauma like a car accident or severe sports injury. Even with acute traumas the extent of the injuries is most often dependent on your health before the accident. Your answers to the following questions offer up clues to what dangers your body is currently encountering and will give us a base line for comparison to future outcomes.

2. DISEASE CAUSATION ANALYSIS

We will explore which lifestyle factors are affecting your overall health and your ability to live fully alive. It is a well-known fact that 80% of the risk factors for the two most feared killers; heart disease and cancer, are lifestyle related. The same is true for the majority of chronic illnesses affecting patients today.

Let's get started in understanding your problem and finding a solution.

Rocket City Chiropractic

DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home #: _____ Age: _____ Birth date: _____

Workplace: _____ Office #: _____ Occupation: _____

❍ Single ❍ Married ❍ Widowed

Social Security #: _____ ❍ Separated ❍ Divorced (SPOUSE'S NAME): _____

#of Children: _____ and their ages: _____ Referred by: _____

Dinner Talk, Lunch & Learn, Fit For The King

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year:_____Injuries: _____
Year:_____Injuries: _____
Year:_____Injuries: _____

❍ High Speed Collisions >25 mph? ❍ Vehicles unrepairable?
❍ Whiplash injury? ❍ Un-belted accident?

FALLS

Falls from heights _____
Falls down stairs _____
Other falls _____
Broken bones _____
Childhood falls _____

Falls from:

❍ Trees ❍ Roof ❍ Play structure ❍ Bicycle

POSTURES & HABITS

❍ Sitting>6 hours/day ❍ Stomach sleeper
❍ Head forward posture

SPORTS & RECREATION:

Sports injuries: _____

Participation in High Impact Activities:

❍ Football ❍ Wrestling ❍ Basketball
❍ Running ❍ Mountain bike ❍ Climbing
❍ Baseball ❍ Gymnastics ❍ _____

OCCUPATIONAL STRESSES

Occupation_____
Tasks_____
Work injuries_____

Home injuries_____

My job requires:

❍ Heavy Lifting ❍ Awkward positions
❍ Repetitive stresses ❍ Sitting long periods

BIRTH TRAUMA was your delivery

❍ Difficult ❍ Forceps ❍ C-section
❍ Epidural ❍ Suction ❍ Resuscitation

DISCOVERY - HEALTH DANGERS

WHAT IS YOUR PRESENT HEALTH CONCERN?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition in the past?

_____

What activities aggravate your condition?

_____

What relieves your condition?

_____

Are you getting pain or numbness in your arms or legs?

_____

Is your condition getting progressively worse?

❍ Yes ❍ No ❍ It's constant ❍ It comes and goes

Pains are: ❍ Sharp ❍ Dull ❍ Burning

❍ Tightness ❍ Throbbing

Pain severity (mark on the line, 0 no pain; 10 most severe)

0……..……..……10

How is this condition interfering with your life?

❍ Work ❍ Daily Routine ❍ _____

Other doctors who treated this condition:

_____

FAMILY HEALTH PROBLEMS?

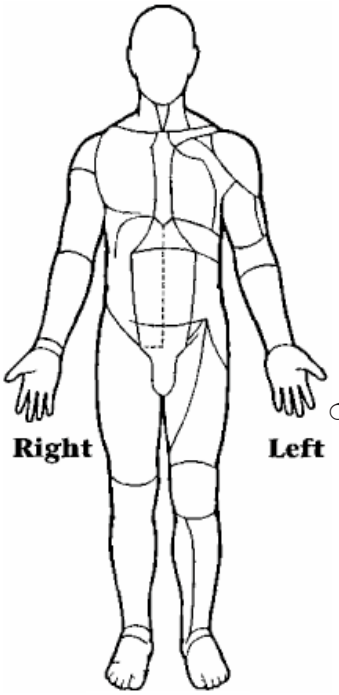
_____

_____

_____

_____

MARK WITH AN X ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS AND CHECK THE APPROPRIATE CIRCLE BELOW:



❍ Headaches ❍ Facial pain

❍ Vision problems ❍ Hearing problems

❍ Shoulder: Pain / Numbness / Tingling (circle)

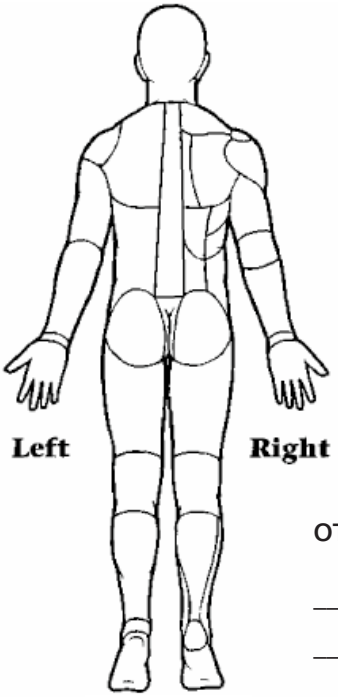
❍ Arm: Pain / Numbness / Tingling (circle)

❍ Hand: Pain / Numbness / Tingling (circle)

❍ Hip: Pain / Numbness / Tingling (circle)

❍ Knee: Pain / Numbness / Tingling (circle)

❍ Foot: Pain / Numbness / Tingling



❍ Neck Pain

❍ Upper Back Pain

❍ Middle Back Pain

❍ Low Back Pain

❍ Sacroiliac Pain

OTHER HEALTH PROBLEMS?

_____

_____

_____

_____

DISCOVERY - HEALTH DANGERS

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED:

❍ Blurred /failing vision
❍ Deafness /ringing in ears
❍ Earaches
❍ Sore throat /tonsillitis
❍ Thyroid problems
❍ Sinus problems

Cardiovascular system

❍ Chest Pain
❍ Shortness of Breath
❍ Heart Medication
❍ High Blood Pressure Medication
❍ High Cholesterol Medication
❍ Swelling of Legs

Respiratory system

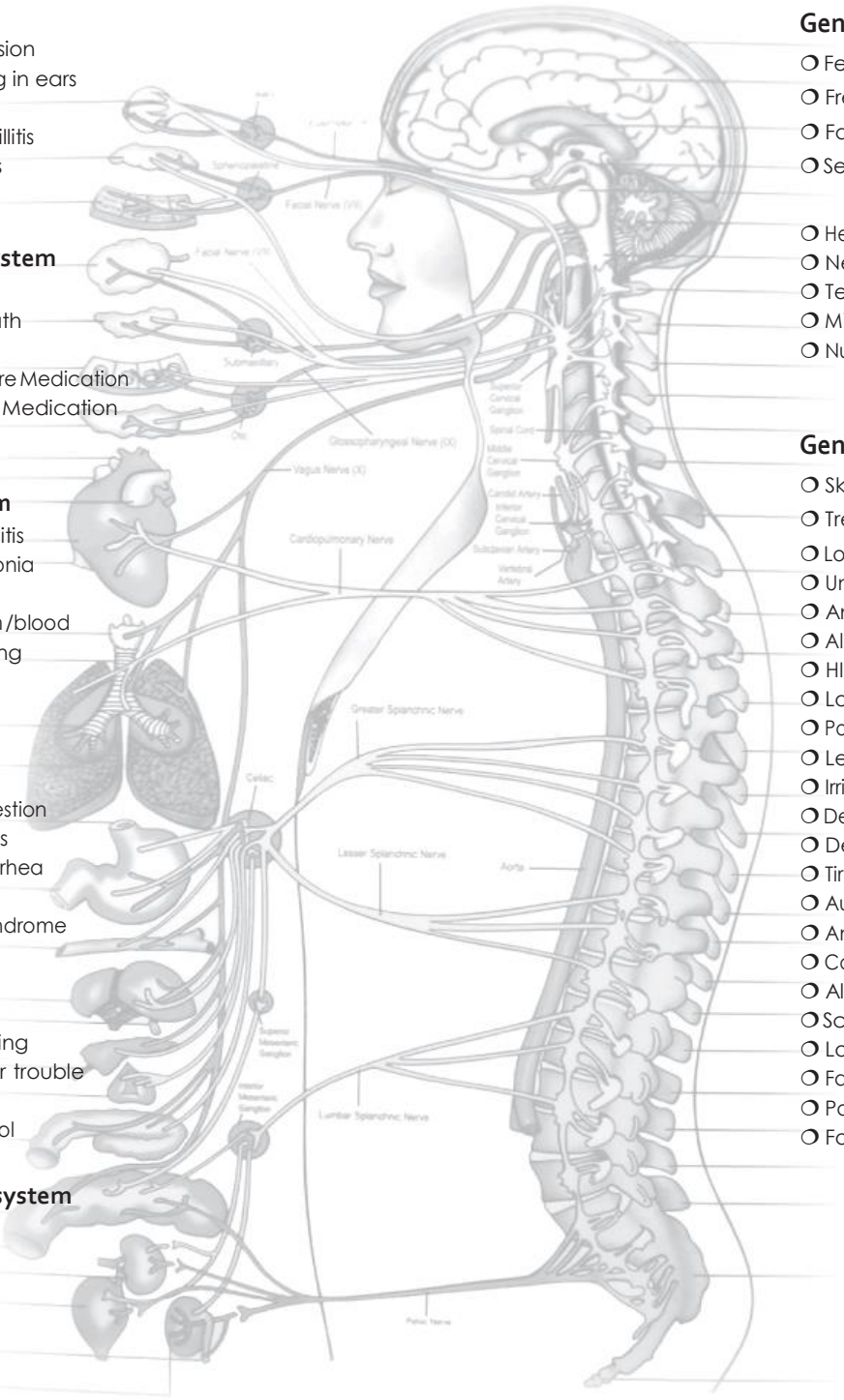
❍ Frequent bronchitis
❍ History of pneumonia
❍ Chronic cough
❍ Spitting up phlegm /blood
❍ Difficulty breathing
❍ Tuberculosis
❍ Pneumonia

Digestive system

❍ Heartburn / indigestion
❍ Stomach Cramps
❍ Constipation /diarrhea
❍ Food Allergy
❍ Irritable Bowel Syndrome
❍ Crohn's Disease
❍ Ulcers
❍ Belching /gas
❍ Nausea or vomiting
❍ Liver /gall bladder trouble
❍ Colon trouble
❍ Black /bloody stool

Musculoskeletal system

❍ Painful Joints
❍ Painful Muscles
❍ Tendinitis
❍ Bursitis
❍ Arthritis



General Symptoms

❍ Fever / chills /sweats
❍ Frequent colds
❍ Fainting / dizziness
❍ Seizures / convulsions

❍ Headaches /migraine
❍ Neck pain /stiffness
❍ Tension across shoulders, L R
❍ Mid-back pain /stiffness
❍ Numbness /tingling: hands /arms

General Symptoms

❍ Skin problems
❍ Tremors
❍ Loss of balance
❍ Unexplained weight loss/gain
❍ Anemia
❍ Alcoholism
❍ HIV/AIDS
❍ Loss of sleep
❍ Poor memory /concentration
❍ Learning disability
❍ Irritable /nervous /tension
❍ Depression /emotional problems
❍ Decreased energy / fatigue
❍ Tired /lethargic
❍ Autoimmune Disease
❍ Antibiotic Use
❍ Cancer: _____
❍ Allergies / Asthma
❍ Scoliosis / spinal curvature
❍ Low back pain / stiffness
❍ Faulty posture
❍ Painful tailbone
❍ Foot trouble, L R

Females Only

❍ Painful menstruation
❍ Cramps or backaches
❍ Passed menopause
❍ Currently pregnant? ❍ Y ❍ N
❍ Excessive /irregular flow
❍ Abnormal discharge
❍ Miscarriages #_____
❍ Date of last menstrual period: _____

DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

How has your condition affected your quality of life? _____

_____

How has your condition affected you emotionally? _____

_____

How has your condition affected your family life and/or relationships? _____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

If you are a candidate for corrective care and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition?
(Mobility, quality of life, family, participation in sports, etc.) _____

_____

Do you believe that this condition can improve? _____

_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Assignment and Release: I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc. And hereby provide my consent for treatment. I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. James Olszewski (Chiropractor) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of their signature on all insurance submissions.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-treatment for unusual findings, we will advise you. If you advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or health issue is classified, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

REGARDING XRAYS/IMAGING STUDIES→ Please read carefully and check the boxes, then sign below if you understand and have no further questions, otherwise see our receptionist for more explanation.

FEMALES ONLY→ ❑ I am **pregnant** and will not receive x-rays

❑ I am **not pregnant** and I am able to receive x-rays

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

After careful consideration I therefore, do hereby consent to have diagnostic x-rays the doctor has deemed necessary in my case.

I have read the above statements and consent to treatment.

Signature _____ Date _____

DISEASE CAUSATION - ANALYSIS

EXERCISE

Do you participate in aerobic exercise at least 30 minutes per day?

❍ 0 days /week ❍ 1-2 days /week
❍ 3-4 days /week ❍ 5-7 days /week

Do you lift weights or do resistance training?

❍ P90x
❍ CrossFit
❍ Gym
❍ Other _____

What activities are you involved in that require balance?

❍ _____ ❍ None

How often do you stretch per week?

❍ 0 days /week ❍ 1-2 days /week
❍ 3-4 days /week ❍ 5-7 days /week

EMOTIONAL STRESS

Are you currently experiencing, or have you ever experienced significant stress in the following areas?

❍ Marriage _____
❍ Kids _____
❍ Finances _____
❍ Work _____
❍ Elderly Parents - Caregiver _____
❍ Recent Major Life Events (births, deaths) _____
_____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

Parents / Siblings: _____
_____

Spouse / Partner: _____
_____

Children: _____
_____
_____

PREVIOUS CHIROPRACTIC CARE

Have you ever been to a chiropractor before? _____
Was it a positive experience? _____
If NO, please tell us why? _____
_____
Was your care short-term pain relief or long-term structural correction? _____
Did you follow the Doctor's recommendations? _____
If NO, please tell us why? _____
_____

CHEMICAL STRESSES: NUTRITION

Do you feel that you make healthy food choices?

❍ Yes ❍ No ❍ Don't Know

Do you have a high intake of fruits and vegetables?

❍ Yes ❍ No ❍ Don't Know

Do you have a high intake of lean meat for protein?

❍ Yes ❍ No ❍ Don't Know

Are you at your ideal body weight?

❍ Yes ❍ No ❍ Don't Know

CHEMICAL STRESSES: TOXIC LOAD

Do you presently, or have in the past:

❍ Smoke? ❍ Carry excessive weight?
❍ Consume Alcohol? ❍ Take recreational drugs?

MEDICATIONS

For what condition(s)? _____
_____
_____
_____
_____
_____

SURGERIES

For what condition(s)? List (year performed) _____
_____
_____
_____
_____
_____

Any other details that may assist the Doctor in understanding your lifestyle and health status:

_____
_____
_____
_____