Life Enhancement Chiropractic

PATIENT HEALTH ASSESSMENT

Patient Name: _____ Today's Date: ____/____/____ File No.:_____

Home Address: _____ Date of Birth: ____/____/____ Sex: ❑ Male ❑ Female

City: _____ State:_____ Zip:_____ Home Phone #:_____

Social Security #:_____ Preferred 1st Name: _____ Work Phone #:_____

Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Spouse's Name: _____ Children? ❑ Yes ❑ No

Employer: _____ Occupation: _____ Ages? _____

Employer's Address: _____ City: _____ State: _____ Zip:_____

Insured's Name: _____ Insured's DOB: ____/____/____ Relation to Patient:_____

Insured's S.S. No.: _____ Primary Care Physician: _____ Ins. Co:_____

Insured's Employer: _____ Insured's Occupation: _____ How Long?_____

Member No.: _____ Group No.: _____ Group Name:_____

PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK AFTER COMPLETING THESE FORMS

COMPLAINT HISTORY:

1. Describe your current complaint(s): 1.) _____

2.) _____

3.) _____

2. How long have you had this episode of symptoms? _____ Date of Onset: ____/____/____ Time of day: _____ AM/PM

3. How many days have you experienced symptoms prior to seeking care here? ❑ Less than eight days ❑ More than eight days

4. The number of previous episodes of the current complaint you have experienced in your lifetime? **Think carefully, this is very important!**

❑ 0-3 Previous Episodes ❑ 4-7 Previous Episodes ❑ 8 or more Previous Episodes

5. Describe the pain:

❑ Dull ❑ Ache ❑ Sharp ❑ Stiffness ❑ Spasm ❑ Soreness ❑ Boring
❑ Shooting ❑ Burning ❑ Throbbing ❑ Weakness ❑ Numbness ❑ Tingling ❑ Stabbing

6. Rate the intensity of the pain: **(Circle the appropriate number)**

0 1 2 3 4 5 6 7 8 9 10

No Pain Low Pain Moderate Pain Intense Pain Emergency

7. How often is the pain present?

❑ Constant (81-100%) ❑ Frequent (51-80%) ❑ Occasional (26-50%) ❑ Intermittent (25% or less)

8. Time of the day when your problem is the worst? _____ AM/PM Time of the day when your condition is the best? _____ AM/PM

9. Since your problem began is the pain **or** dysfunction:

❑ Getting worse ❑ Getting Better ❑ Staying the same

10. How did your problem begin?

❑ Gradual ❑ Sudden ❑ No Specific Reason ❑ Auto Accident ❑ Work Accident

Explain what triggered your problem:_____

11. What makes your problem better?

❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Movement ❑ Certain Position, if so describe:_____
❑ Massage ❑ Ice ❑ Heat ❑ Exercise ❑ Inactivity ❑ Lying down

12. What makes your problem worse?

❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Movement ❑ Certain Position, if so describe:_____
❑ Massage ❑ Ice ❑ Heat ❑ Exercise ❑ Inactivity ❑ Lying down

13. Were you previously treated for an earlier occurrence of this same condition? ❑ Yes ❑ No

If yes, by whom? ❑ MD/DO ❑ Chiropractor ❑ Phys. Therapist ❑ Other:

Dr's. Name and location: _____ Were X-rays taken? ❑ Yes ❑ No

Approximate dates, type and results of treatment: _____

14. List all prescription & over the counter medications with their respective dosages that you are currently taking:

_____

15. List all vitamins, mineral & herbal supplements with their respective dosages that you are currently taking:

_____

16. Do you exercise?

❑ No regular exercise ❑ 1-2 times a week ❑ 3-4 times a week ❑ 5-7 times a week
❑ Cardiovascular exercise ❑ Stretching ❑ Machine Weights ❑ Free Weights ❑ Other_____

17. Rate your general stress level:

❑ No stress ❑ Minimal stress ❑ Moderate stress ❑ Intense stress

18. Is your problem affecting your ability to work or perform normal daily activities?

❑ No effect ❑ Some limited physical restrictions, but can function ❑ Need some assistance with daily activities
❑ Can not work ❑ Can not function without assistance ❑ Totally disabled

19. Lifestyle:

❑ Tobacco use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy
❑ Alcohol use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy
❑ Coffee, tea & soda use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy
❑ OTC drug (aspirin ...) use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy

20. Family Medical History:

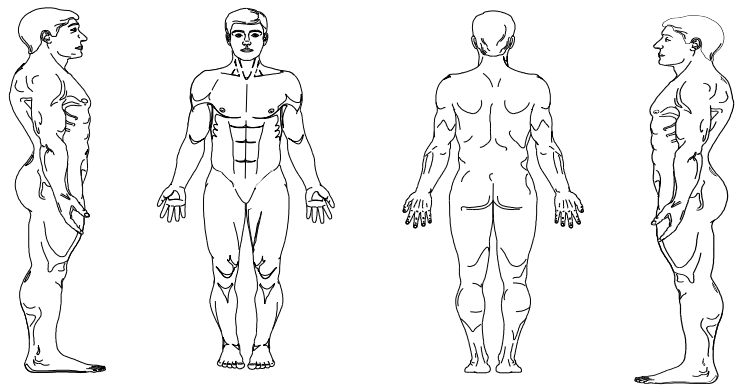
Father: ❑ Alive ❑ Deceased at Age ____ ❑ Medical Conditions: _____
Mother: ❑ Alive ❑ Deceased at Age ____ ❑ Medical Conditions: _____
Siblings: ❑ Alive ❑ Deceased at Age ____ ❑ Medical Conditions: _____

PAST or PRESENT SYMPTOMS/CONDITIONS:

Symptom/Condition	Past	Present	Symptom/Condition	Past	Present	Symptom/Condition	Past	Present
Neck pain	❑	❑	Artificial Bones/Joints	❑	❑	Menstrual problems	❑	❑
Shoulder pain	❑	❑	High/Low blood pressure	❑	❑	Breast soreness/lumps	❑	❑
Arm/Elbow pain	❑	❑	Heart condition/pacemaker	❑	❑	Gynecological disorder	❑	❑
Wrist/Hand pain	❑	❑	Allergies/Asthma	❑	❑	Pregnancy	❑	❑
Upper back pain	❑	❑	Respiratory condition	❑	❑	Skin condition	❑	❑
Lower back pain	❑	❑	Sinus condition	❑	❑	Diabetes - Type I/Type II...	❑	❑
Hip/Thigh pain	❑	❑	Stroke/Vascular disease	❑	❑	Excessive/Difficult urination	❑	❑
Knee/Leg pain	❑	❑	Gastrointestinal condition	❑	❑	Diarrhea/Constipation.....	❑	❑
Ankle/Foot pain	❑	❑	Kidney/Urinary Bladder....	❑	❑	Prostate condition .	❑	❑
Jaw pain/Jaw dysfunction…	❑	❑	Liver/Gallbladder	❑	❑	Fainting/Seizures/Epilepsy	❑	❑
Headaches	❑	❑	Eye/Ears/Nose Condition	❑	❑	Dizziness/Ringing of ears	❑	❑
Arthritis/Swollen/Stiff joints	❑	❑	Excessive weight loss/gain	❑	❑	Anemia/Blood disorder.....	❑	❑
Skeletal anomaly/Scoliosis	❑	❑	Cancer/Leukemia	❑	❑	Plastic Surgery	❑	❑
Disc Disease/Herniation ...	❑	❑	Psychiatric condition	❑	❑	Sexual Disease/HIV+/AIDS	❑	❑
Trouble Sleeping	❑	❑	Height_____			Weight_____		

Use the symbols below to locate & describe your condition:

Aching:	Numbness:	Pins & Needles:	Burning:	Stabbing:
xxxxxx	----------	oooooooooooooo	^^^^^	●●●●●



List any other medical condition(s) you've experienced:

_____

List any surgeries &/or hospitalizations w/ dates:

_____

Last any accidents, sports injuries, falls, etc. w/ dates:

_____

If you would feel more comfortable with another person present during the exam &/or treatments, please inform the Doctor verbally and check the appropriate box:

❑ Yes this is important to me ❑ No this isn't an issue

_____

Patient's Signature **Date**

_____

Examining Doctor's Initials Date

Life Enhancement Chiropractic PATIENT HEALTH ASSESSMENT cont.

Do you have numbness or tingling in the arms/hands? □Yes □No

Explain: _____

Do you have numbness or tingling in the legs/feet? □Yes □No

Explain: _____

List the extent of your injuries as you know them: _____

_____

_____

_____

_____

_____

_____

Are your symptoms aggravated by any of the following?

Sitting	□Yes □No	Shaving	□Yes □No
Driving	□Yes □No	Getting Dressed	□Yes □No
Walking	□Yes □No	Crossing legs	□Yes □No
Standing	□Yes □No	Reading	□Yes □No
Bending	□Yes □No	Using computer	□Yes □No
Lifting	□Yes □No	Watching TV	□Yes □No
Climbing stairs	□Yes □No	Cold/humid Weather	□Yes □No
Washing dishes	□Yes □No		

Household chores □Yes □No Explain: _____

_____

Other aggravating activities. Explain: _____

_____

Do any work activities aggravate pain? □Yes □No Explain: _____

_____

_____

What activities can you no longer participate in? (Exercise, etc.…)

_____

_____

What gives you relief? Explain: _____

_____

_____

What type of medications are you currently taking? (Over-the-Counter or Prescribed)Name of your insurance company:

_____

_____

Other Doctors seen: _____

INSURANCE INFORMATION

Is this condition due to: A work-related injury □ Yes □ No Automobile Accident □ Yes □ No

Claim Number: _____

Are you covered by Medicare? □ Yes □ No

Do you have Major Medical Health Insurance? □ Yes □ No

Company: _____

COMPLETE:

Date of accident or injury: _____ Time of accident_____

Location: _____

How did accident occur? □ Auto collision, □ Work, □ Sports, □ Other _____

_____

Weather conditions: □Dry □Wet □Light □Dark □Icy

If auto accident, were you: □Driver □Passenger □Front □Rear □Pedestrian

If auto collision, were you struck from: □Behind □Passenger side □Driver side □Front □Auto was parked

Were you wearing a seat belt: □Yes □No Were you wearing a shoulder harness: □Yes □No

Did your car strike other(s) involved? □Yes □No

Or did the other car(s) strike yours? □Yes □No □Undetermined

As a result of the accident, were traffic citations issued to you? □Yes □No

As a result of the accident, were traffic citations issued to the other driver? □Yes □No

As a result of the accident, were traffic citations issued to the driver of your car? □Yes □No

Were you aware of pending impact? □Yes □No

Did the airbags deploy? □Yes □No

Was there any head trauma? □Yes □No

Dis you lose consciousness? □Yes □No. For how long? _____

Were you disoriented? □Yes □No For how long? _____

Did you require post-accident hospitalization? □Yes □No X-Rays taken: □Yes □No

How did you get to the hospital? _____

What was the name of the hospital? : _____

Have you lost any days of work? □Yes □No Dates: _____

Are you working now? _____

Company or person responsible for injuries: _____

Has an insurance adjuster or company representative regarding this claim contacted you? □Yes □No

COMPLETE ONLY FOR JOB INJURY INFORMATION:

Workman's Compensation Case Number_____

Insurance Company_____

Insurance Company Case Number_____

Employer's Name_____

Employer's Address_____

Cell Phone: _____

E-Mail: _____

Height: _____ Weight: _____

Right handed ☐ Left handed ☐

List any health conditions that you would like to resolve?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

I hereby assign my insurance company and/or attorney to pay directly to Dr. George Logothetis or life enhancement chiropractic monies due for services rendered which would otherwise be payable to me.

PATIENT'S SIGNATURE _____ DATE_____

GUARDIAN/SPOUSE'S _____DATE_____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Dr. George E. Logothetis and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my

(Son's/daughter's Name)_____

PARENT/GUARDIAN'S SIGNATURE_____DATE_____

DOCTOR'S SIGNATURE _____ DATE_____
George E. Logothetis, D.C.

LIFE ENHANCEMENT FAMILY CHIROPRACTIC
Dr. George E. Logothetis
68 Summit Ave, Hackensack, NJ 07601
Tel. 201-489-1500* Fax 201-489-1516**

CHIROPRACTIC TREATMENT INFORMED CONSENT

I have had been explained the purpose of & been given a description of the performance of spinal manipulative therapy (SMT) and other adjunctive therapeutic procedures relative to my condition. I understand that the results of treatment are not guaranteed.

I hereby request and consent to the performance of SMT and other necessary procedures (including but not limited to: various modes of physical therapy & diagnostic x-rays) by qualified clinic personnel.

I have been informed that some patients may experience discomfort or other symptoms after physical examinations, physical therapy modalities and SMT. If any discomfort or symptoms do occur, I will immediately contact my doctor. If I am out of town or unable to contact my doctor, I may present myself to an emergency room.

Although studies have proven chiropractic care to be safer and more effective than medical care for neuromusculoskeletal conditions. (i.e. Manga Report) there are potential risks to treatment. The potential risks, albeit very slight, include but are not limited to: muscle strains, sprains, disc injury and cerebral vascular accidents. Studies which have quantified SMT risks:

1) If you drive about eight miles each way to get to your chiropractic appointment, you have a statistically **greater risk** of being seriously injured in a car accident while traveling to the Doctor's office than having a serious complication from a cervical spinal manipulation.

2) For the treatment of neck pain, NSAIDs (i.e. Advil, Motrin, Naprosyn ...) were found to be associated with a very low risk of serious complications. However, the incidence of serious complications among people who received cervical spinal manipulation was determined to be up to 400 **times lower** than those people who utilized NSAIDs for the treatment of neck pain.

The doctor shall review the results of any laboratory tests or other diagnostic procedures performed outside of this office at the time of my next scheduled appointment.

I have read the above consent, with the doctor. I have reviewed each section, item by item. I have also had an opportunity to ask questions about its content. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____	_____	_____
Patient's Signature	Date	Doctor's Signature

LIFE ENHANCEMENT FAMILY CHIROPRACTIC
Dr. George E. Logothetis

68 Summit Ave, Hackensack, NJ 07601
Tel. 201-489-1500* Fax 201-489-1516**

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:
You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices:
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures:
How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:
- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request.

Contact information:
Dr. George E. Logothetis, DC
68 Summit Ave, Hackensack, NJ 07601
201 489 1500

Attachment 5

PATIENT ACKNOWLEDGEMENT OF HIPPA NOTICE

LIFE ENHANCEMENT FAMILY CHIROPRACTIC
Dr. George E. Logothetis
68 Summit Ave, Hackensack, NJ 07601
Tel. 201-489-1500* Fax 201-489-1516**

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgment:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

For Office Use Only:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ The patient refused to sign.
___ We were not able to communicate with the patient.
___ Due to an emergency situation it was not possible to obtain a signature.
___ Other (please provide details):
_____

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

LIFE ENHANCEMENT FAMILY CHIROPRACTIC

Dr. George E. Logothetis

68 Summit Ave, Hackensack, NJ 07601

Tel. 201-489-1500* Fax 201-489-1516**

ASSIGNMENT OF BENEFITS

Patient's Name: _____

In consideration of the professional services rendered by Life Enhancement Family Chiropractic and all physicians associated with my treatment, I, hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for PIP insurance benefits with regard to above-captioned claim ton Health Care Providers, including but not limited to surgical fees, supplies, primary physicians, assistant, anesthesia, and any other fees related to my claim.
2. The authorization of Health Care Providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of denial of my claim.
3. The authorization of Health Care Providers to initiate and prosecute any and all appeals and/or arbitrations or legal actions on the denial of my claims, including but not limited to internal appeals with the insurer as well as PIP arbitrations.
4. The authorization of Health Care Providers to obtain and/or disclose any Private Health Information as contemplated by HIPAA authorization in this regard.
5. The authorization of Health Care Providers to file a complaints with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/ or the insurer.
6. The authorization for payment of any and all PIP insurance benefits directly to Health Care Providers to which I might be entitled under the above-captioned claim.

_____ _____

Patient Signature (Parent/ Legal Guardian) Date

LIFE ENHANCEMENT FAMILY CHIROPRACTIC
Dr. George E. Logothetis D.C.
68 Summit Avenue
Hackensack, NJ 07601
201-489-1500

THANK YOU FOR SELECTING US
FOR YOUR CHIROPRACTIC HEALTH CARE.

PLEASE FEEL CONFIDENT
THAT WE WILL DO OUR BEST
TO PROVIDE YOU WITH
FRIENDLY AND EFFECTIVE SERVICE.

WE LOOK FORWARD TO SEEING YOU AGAIN!

SINCERELY,

DR. GEORGE E. LOGOTHETIS
& THE LIFE ENHANCEMENT STAFF

CHIROPRACTIC CARE, FOR BETTER HEALTH, FOR A BETTER LIFE, FOR ALL PEOPLE, FOR ALL AGES, FOR ALL REASONS

Our Goal is to optimize patient neuromusculoskeletal and neurophysiological function and health through appropriate spinal adjustments, adjunctive therapeutic techniques, and nutritional advice. We advocate a team concept toward health care by making appropriate referrals to other health care providers to best serve patient needs. Treat patients respectfully and ethically while improving their health and well being.

Our mission is to direct people to the realization that they are activated from within; that life and healing come from within; and ultimately that the maintenance of health is superior to the treatment of disease.

Our Practice Philosophy

Chiropractic may very well be one of the least understood philosophies of life and health. It is based upon a few very simple principles.

The body is designed with an inborn ability to maintain itself in a state of proper function. A newborn baby may seem small, fragile and helpless, but within that body is the ability to make food into living tissue, to heal cuts and bruises, to adapt to changes in the environment, to produce the chemicals necessary to perform every bodily function, to fight off invading organisms, to live as much as 100 or more years, to lead a healthy, productive life.

The brain and nerve system are the primary tools by which we attain proper function, what we commonly call health. Every organ, gland and cell in the body depends upon messages carried to and from the brain in order to function in a coordinated manner so that each part can benefit the whole of the body producing a full and abundant life.

Interference in the nerve system reduces the body's ability to function in a coordinated manner. While a corpse has a brain and nerve system, it does not have life, there is no power or energy flowing over the nerve system. Similarly, a paralyzed person has lost function due to injury to the nerve system. Even slight damage to the delicate and vital nerve system can reduce the body's ability to function at its fullest potential.

A spinal misalignment that interferes with the nerve system (called a vertebral subluxation) creates a reduction in coordinated function. Slight misalignments of the bones of the spine caused by everyday, common activities can interfere with the ability of the nerve system to carry messages that are necessary for the successful accomplishment of those everyday activities, not the least of which is the attainment of maximum health.

Chiropractors correct vertebral subluxations. The single objective of the chiropractor is to locate and correct vertebral subluxation in adults and children so that families and entire communities are able to express life at a higher level.

It about health wellness and what makes people live.

If you are not seeing a chiropractor regularly, you are not doing all you should for your life and health.

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What to Expect!

- Our goal is to provide corrective care to the spine and nervous system.
- During the initial phase of care you may experience soreness or an increase in your symptoms. **This is a normal part of the corrective/healing process.**
- X-rays, if needed will be taken. In most cases we want to initiate a changes prior to taking x-rays.
- An exercise or stretching program will be provided. In some cases we will wait until your symptoms begin to subside.
- If you follow the doctor's care plan we are certain that you will be satisfied with the results.

Our mission is to direct people to the realization that they are activated from within; that life and healing come from within; and ultimately that the maintenance of health is superior to the treatment of disease.