Dr. Jessica Rose DC

Client Health History

Name: _____ Date: _____
(First) (Middle) (Last) (Pronouns)

Email: _____ Best phone: H / C_____

Street Address: _____

City/zip: _____ Date of Birth: _____ Marital Status: _____

Emerg. Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office? _____

This is an opportunity to be present and reflect upon your health and well-being.
Your insights will help us create a supportive and empowering care experience together. Thank you.

1. Please share why you are drawn to this work and the specific areas of health, wellness, evolution, spirituality, or transformation where you seek support: _____

   _____

2. If your desired change were to occur tomorrow, what would be different about your life? _____

   _____

3. Have you received previous support or treatment for this? Yes ❑ No ❑ If yes, when? _____
   What care did you receive? What were you told? What support did it offer? _____

   _____

4. Please rate how the above piece(s) impact the following aspects of your functioning and quality of life:
   0 - Does not seem to affect me 1 - Slightly affects me 2 - Moderately affects me 3 - Drastically affect me

   Work: 0 1 2 3 Rest/sleep 0 1 2 3 Eating 0 1 2 3 Social life 0 1 2 3 Recreation/ Play 0 1 2 3

   Sitting 0 1 2 3 Walking 0 1 2 3 Exercise: 0 1 2 3 Love life 0 1 2 3 Concern about health 0 1 2 3

5. Have other family members had the same or similar health concerns? Yes ❑ No ❑ If yes, please elaborate:

   _____

6. Please list prescription medications, over-the-counter medications, vitamins, and supplements you are currently taking: _____

   _____

7. Have you had spinal injuries, broken bones or significant sprains? Yes ❑ No ❑ Have you had a work or auto-collision-related injury? Yes ❑ No ❑ If yes to either, when and what happened? _____

   _____

8. Have you any surgeries or been hospitalized? Yes ❑ No ❑ If yes, for what reason and when? _____

   _____

9. Has your ever received professionally spinal adjustments or entrainments? Yes ❑ No ❑
   a) By whom and when? _____
   b) Were you pleased? Yes ❑ No ❑ c) Are you still going? Yes ❑ No ❑

10. If you receive ongoing medical care, beyond regular checkups, please list condition(s) and date of last visit:

_____

11. **Systemic Stress Survey:** Please grade the following stresses:
0 - no awareness of stress 1 - slight stress 2 - moderate stress 3 - extreme stress

Overall Physical Stress: 0 1 2 3 Please circle current experiences and underline past experiences:

falls accidents injuries repeated postural stress difficult birth physical abuse severe fatigue

sexual difficulties live births: # __ pregnancies: #__ Other: _____

Overall Chemical Stress: 0 1 2 3 Please circle current experiences and underline past experiences:

prescription drugs over-the-counter drugs recreational drugs alcohol smoke pollutants

food additives mold mercury fillings Other: _____

Overall Emotional/Mental Stress: 0 1 2 3 Please circle current experiences and underline past experiences:

loss of loved ones rapid life changes mental/emotional abuse sexual abuse grief nervousness

legal or financial concerns move home change school stress of being ill depression anxiety

change in relationship with significant other sexism racism Other: _____

12. This is a space to share any significant events or experiences, including those that may have felt traumatic to you or your family of origin. Please share whatever feels important for our work together. _____

_____

_____

Lifestyle:

1. Occupation: _____ Employer: _____ Hours/Wk: _____

Do you enjoy work? Yes ❑ No ❑ Why/Why not? _____

2. Do you have an exercise, meditation, prayer, nutritional, or dietary program? Yes ❑ No ❑ If yes, please describe: _____

3. Water consumption per day: _____

4. Nicotine/Alcohol/Caffeine Use: _____

5. What do you love? What brings you alive? What helps you center and feel authentically you? _____

_____

6. Are there aspects of life, experiences, family, work, recreation, past injuries, genetics or outlook you feel:

impair your full glowing health? _____

support your full glowing health? _____

Thank you for taking this step towards greater well-being.
I am excited and honored to support you on your journey.

Dr. Jessica Rose DC

Consent for Care & Client Responsibilities

Congratulations on choosing to begin Network care. It is an honor to serve you and I am committed to providing exceptional service. The purpose of this form is to explain the services you will receive and the mutual responsibilities of being a client of Dr. Jessica Rose.

Financial Exchange:
Your first 60-minute visit ($150 – paid at visit) includes an introduction, health history review, focused exam, and your first Network entrainment/ adjustment with Dr. Jessica.

Network Care Group Entrainments* (20-30 minutes):

- Network Entrainment: $75
- Parent & Child (ages 0-14): $75
- Parent & Child (age 15-19): $105
- Accessible Care - BIPOC: $45 (if cost is a barrier to care)
- Child (0-19): $40

* Payment is due when scheduling online. If needed, please reach out to make other arrangements.

Cancellation Policy:
Please provide 24 to 48 hours' notice for cancellations. Missed appointments or cancellations without 24-hour notice are non-refundable. Please reach out if there are extenuating circumstances.

___ I understand that missed or cancelled appointments without 24-hour notice are non-refundable.
(initial)

Session Descriptions & The Nature of Care:
During your Network Entrainment (adjustment) Dr. Rose will apply gentle spinal contacts and may guide you to focus on and breathe into specific areas. This individualized care, offered alongside 1-2 others on separate tables, supports brain-body communication, spinal and nervous system reorganization, and neuromuscular re-education.

Network Care does not include manual manipulation or focus on directly treating painful areas. Instead, it promotes unique spinal wave motions, body movements, and oscillations that increase body (somatic) awareness, especially of the spine. This increased awareness supports new strategies for healing, effective stress responses, postural changes, and overall wellness.

Individuals receiving care often breathe more deeply, naturally adopt postures that release or redistribute tension and stress, and experience increased energy. Many clients report a wider range of motion and emotions, along with enhanced well-being, self-empowerment, self-compassion, and self-love.
This care can lead to fundamental lifestyle changes and shift your perception of the world.

This form of care is NOT suggested for individuals who wish to remove a symptom or condition without the occurrence of other fundamental life changes. Care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness. Rather than attempt to return you to your previous state minus a symptom, Dr. Jessica Rose is honored to help you achieve new, evolutionary levels of wellness and life potential.

Chiropractic care in Washington state focuses on identifying and correcting the vertebral subluxation complex, a form of nervous system interference, to restore and maintain health and well-being and allow for a free flow of innate (inner) intelligence and its recuperative powers through the body. I am required that the following information be given to you and signed prior to care. Through gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office. The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom.

As with any healthcare procedures, the body may respond in various ways to care. Please notify Dr. Rose, if you have concerns about any unexpected or seemingly adverse reactions, often referred to as a *healing crisis*. She will gladly support you through this response or refer you to a practitioner who can.

__ (initial) I understand I am an active participant in this care. It is my responsibility to consider the advice and recommendations provided to me, as well as educate myself on the efficacy, risks and appropriateness for my body.

Privacy Practices
Healthcare records maintained by this office will be kept confidential and released only upon your written request. By signing this form, you confirm that you have received or are declining a copy of our Notice of Privacy Practices, as required by law.

In this office, clients often work with multiple practitioners. Collaborative care often benefits both clients and practitioners. By signing this form, you consent to allow your practitioners to confer. If you have restrictions on this collaboration, please indicate them below. Thank you.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I have read or had read to me the above Consent for Care & Client Responsibilities form and hereby request and consent to receive care with Dr. Jessica Rose, DC. I enter into this agreement of my own free will, or on behalf of my dependent, without any pressure or promise of cure. I understand the care in this office differs from what many consumers expect from chiropractors practicing manipulative therapy. I am free to withdraw my consent and discontinue care at any time. I also understand that care in this office is not a replacement for the diagnosis or treatment of any symptom, disease, or condition. I understand and agree to the conditions of this document, and my questions have been answered to my satisfaction.

Name: _____

Signature:_____ Date: _____