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

Heart Centered Alignment
Neuro Emotional Technique
Gentle, Holistic Chiropractic

324 West Bay Drive, Suite. 101
Olympia, WA 98502
(360) 789-3134

Consent for Care & Client Responsibilities

Congratulations on choosing to begin care. It is an honor to serve you, and I am committed to providing exceptional service to you and everyone in this practice. This consent form aims to help you understand the services you will receive and the mutual responsibilities of being a client of Dr. Jessica Rose.

Financial Exchange:
Individual hour-long sessions: $150-$225 sliding scale
Initial visit (1½ hrs.): $250
Network Care Group Entrainments (20-30m): $75 (paid online when scheduling)

Preferred payment methods are cash or check. Venmo is available if needed. Upon request, I will gladly provide you with a receipt/superbill to submit to your insurance for potential reimbursement.

Cancellation Policy:
Please provide 24-to-48-hour notice for cancellations. In the absence of 24-hour notice, an $85 fee will apply for missed or cancelled appointments. You are welcome to reach out to discuss extenuating circumstances.

___ (initial) I agree to pay the established fees for my appointments, as well as an $85 fee for any missed appointments or cancellations without 24-hour notice.

Session Descriptions & The Nature of Care:
Chiropractic care in the state of Washington focuses on the removal of 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.

Sessions are tailored to support individuals on their journey of embodiment, evolution and awakening. The chiropractic components of the session may include: Neuro Emotional Technique (NET), Network Spinal, Applied Kinesiology, Activator, Arthrostim, Neuro Modulation Technique (NMT), nutritional advice and wellness education. In session, Dr. Rose may also utilize non-chiropractic healing modalities including but not limited to: Psych-K, mindfulness practices, emotional and belief re-patterning, sound healing and somatic presencing. Sessions may be seated, on the table, or remote.

As part of your session, Dr. Rose may apply gentle spinal contacts or have you contact specific areas, combined with various respiratory patterns, to support brain-body communication, spinal reorganization and neuromuscular re-education. This approach may increase somatic (body) awareness, create more effective stress responses and lead to postural changes.

It is common for individuals receiving care in this practice to experience increased life energy, a broader range of motion and emotions, increased adaptability to stress, and the development of new effective healing and life strategies. Additionally, many report increased body and postural

awareness, greater well-being, deeper breathing, self-empowerment, clearer body-mind communication and the cultivation of self-compassion and self-love. This care can lead to fundamental lifestyle changes and shift your perception of the world.

As with any healthcare procedures, the body may response 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 that I am an active participant in this care. It is my responsibility to consider the advice and recommendations provided to me, as well as to educate myself on the efficacy, risks and appropriateness for my body.

Privacy Practices
Healthcare records maintained by this office will be protected, kept confidential and released only upon your written request. By signing this form, you confirm that you have received (or declined) 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 hereby request and consent to receive care with Dr. Jessica Rose, D.C., and 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 expect from chiropractors practicing manipulative therapy. I am free to withdraw your 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 have read and understand this document, and my questions have been answered to my satisfaction.

Name: _____

Signature:_____ Date: _____

Life is but the expression of spirit through matter.
To make life manifest requires the union of spirit and body.
D.D. Palmer, Chiropractic Founder