Tara Rasta, D.C.
Network Spinal
Statement of Purpose

The purpose in sharing this statement of clinical objectives is to clearly define our approach to health, healing and those we serve in this office. We wish to clearly communicate our responsibilities in this exciting relationship.

The following concepts are central to the way in which we care for others. We are pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

• There is intelligence within each individual which not only keeps that person alive, but also coordinates repairs, renews and heals every cell of the body.

• The nervous system is the main distribution center and coordinating system for this intelligence. Proper coordination, repair, movement, healing and genetic potential cannot be fully expressed when this life power and intelligence is suppressed.

• The purpose of the entrainments given in this office are to clear the nervous system of interference, creating greater communication between your brain, body and life, thus promoting better health, vitality and sense of wellbeing. Everyone, in spite of specific symptoms or ailments, can benefit from more vitality and enhanced wellness.

• Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change. This is central to how we care for others. If you want to become healthier and use your symptoms to motivate change in behavior, you are in the right place!

• By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time required for advancement in care.

• Please have a good relationship with your medical doctor. We will not venture into the practice of medicine by advising about the need for reduction of medications. We suggest you speak with your physician to determine the objectives and goals to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body/mind.

Consistent with the above concepts, we entrain people's nervous systems and care for people using the techniques we believe to be the most honoring and effective.
Sincerely,
Dr. Tara Rasta

I, ____, have read this statement of purpose and understand its contents. I understand that the care offered in this office is not a replacement for any form of treatment provided by other types of practitioners. This office offers *Network Spinal Analysis*, *Somato Respiratory Integration*, *Functional wellness and Specific Chiropractic Adjustments* to promote the natural mechanisms for self-healing and empowerment.
Signature:____
Date:________________________________

Tara Rasta, D.C.

Network Spinal

Health History

Name____ Date _________________

Address____________________________________

City____________________ Zip Code__________________

Phone (H)__________________(O)__________________(C)________________

Referred By___________________

Date of Birth_______________ Age________ Height__________ Weight__________

email_____________________

Your Health Concerns

1. Do you have any current health concerns? If so, please describe:

____

2. When did this situation or concern begin?

____

3. Have you ever been hospitalized? Yes No
If yes, for what reason?

____

4. Have you had any surgery?

____

5. Do you still have all your body parts?

____

6. Have you consulted a physician or any other health care provider in the past three months?
Yes No

7. What is/was the reason for the visit(s)?

____

8. What was done or suggested?

____

9. Please list drugs, when prescribed and reasons for taking them

____

____

10. Do you have an exercise, meditation, prayer, nutritional or dietary program? Yes No
Please Explain

____

11. Have you ever injured your spine (neck, head, back, hips)? Yes No
A. Date of most significant injury:

____

B. What happened?

____

C. Date of most recent injury

____

D. What happened?

____

12. Have you broken any bones or significantly sprained part of your body? Yes No
Please Explain

____

13. How much confidence do you have in your body's ability to heal itself 1-10?
____

14. To what age do you want to live?
____

15. How much do you value your health?
____

16. When stressed, how do you "center yourself" or "re-group"?
____

17. Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel better about yourself?
____

18. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your opportunity for full glowing health?
____

19. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge, or add to your health?
____

20. How do you rate your physical health?
□Excellent □Good □Fair □Poor □Getting □Better □Getting Worse

21. How do you rate your emotional/mental health?
□Excellent □Good □Fair □Poor □Getting □Better □Getting Worse

22. If you consider yourself ill, why do you feel you are ill?
____

23. If you consider yourself well, why do you feel you are well?
____

24. What are some of your healthy sources of energy?
____

25. Where do you get energy that does not really serve you, or is actually unhealthy?
____

26. Are you addicted to anything? (Alcohol, sugar, caffeine, adrenalin, etc.)
____

27. What is the main purpose of your visit today?
____

28. How will you know when your reasons or goals for being at this office have been met?
____

29. What consumes your time that does not give you a wonderful present or future?
____

Thank you for considering the services offered by Dr. Rasta. We look forward to assisting you on your journey of health, wellness and an enriched life.

Social History

Personal habits and frequency per week:

Tobacco________________ Caffeine: ______________ Alcohol _____________

Marijuana______________

Exercises: List types of activities___________________ Frequency per week: _________

Review of System (Please circle if you are experiencing any of the following symptoms):

General
· Fever
· Chills
· Weight Loss
· Weight Gain
· Night Sweats
· Fatigue
· Weakness

Endocrine
· Cold intolerance
· Heat intolerance
· Excessive thirst
· Excessive urination
· Excessive sweating
· Flushing

Skin
· Rash/purple or red spots/pigment change
· Hair loss
· Sun sensitivity/ dry skin
· Hives
· Thickening or tightening of skin
· Calcium deposits
· Fingers/toes turn colors in the cold
· Nodules
· Psoriasis
· Nail problems

Neurologic
· Migraines
· Headaches
· Numbness/tingling
· Muscle weakness
· Incontinence
· Seizures
· Muscle cramps
· Difficulty thinking or Remembering

Eyes
· Vision problems
· Double Vision
· Red eye or pink eye
· History of pink eye as an adult
· Eye Pain
· Dry eyes
· Sandy, gritty sensation in eyes

Allergy
· Frequent sneezing
· Seasonal allergies
· Increased infections

Scalp/Head
· Hair loss
· Scalp tenderness
· Headache
· Jaw pain with chewing

Ears
· Hearing loss
· Earache
· Ear pain
· Swollen ear
· Red ear
· Floppy ear
· Ringing in ears
· Drainage from ear
· Vertigo

Nose
· Runny nose
· Nasal congestion
· Nose bleeds
· Deformity of nose
· Swelling of nose
· Red nose
· Dry nose
· Nose sores
· Loss of sense of smell
· Sinusitis

Mouth
· Sores in mouth
· Dry mouth
· Dental problems
· Loss of taste
· Difficulty swallowing
· Bleeding gums
· Sore throat
· Hoarseness/change in voice
Lungs
· Shortness of breath
· Cough
· Coughing up blood
· Wheezing
· Chest pain with breathing/pleurisy
Heart
· Chest pain
· Stabbing chest pain/pericarditis
· Irregular or rapid heart rate
· Lightheadedness/Passing out
· Sleep on more than 2 pillows due to shortness of breath
· Awakened by shortness of breath
· Leg/ankle swelling
· Color changes in legs/feet
· Leg cramps with walking
· Heart murmur
GI/Abdomen
· Abdominal pain
· Heartburn
· Nausea
· Vomiting
· Difficulty swallowing
· Diarrhea
· Constipation
· Blood in stools
Sleep: Hours/ night:_________________
bedtime:_________ wake time____________

· Mucous in stools
· Jaundice
· History of food poisoning

Genitourinary/Urology
· Pain/burning with urination
· Difficulty urinating
· Urinary incontinence
· Cloudy urine
· Blood in urine
· History of STDs

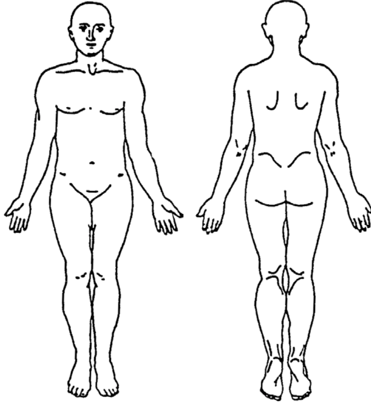
Women only
· Pre-eclampsia or high blood pressure during pregnancy
· History of miscarriage
· Vaginal discharge
· Vaginal ulcers
Men only
· Penile discharge
· Penile ulcers
· Prostate trouble
Blood/Lymph
· Swollen lymph nodes (status post biopsy)
· Blood clots
· Bleeding tendency
· Bruising
· Transfusions
Psychology
· Depression
· Anxiety/Panic Attacks
· Insomnia or Disturbed sleep
· Wake up unrefreshed
· High stress

____

Do you have any addictive behaviors? If yes, list them.

Circle the area of pain & level of pain.

Lowest pain 1 2 3 4 5 6 7 8 9 10 Greatest pain .



When was the first time you experienced this pain?

____

What has made it better and what has made it worse?

____

What emotions do you believe may have contributed to this physical pain?

____

Notice of Privacy Practices for Protected Health Information

I acknowledge that my doctor acts in strict accordance with Federal Privacy Regulations (HIPPA) and that I may request my own copy of the doctor's Notice of Privacy Practices for Protected Health Information at any time.

_______________________________________ ____________

Parent/ guardian signature Date

Informed Consent for Examination and Treatment

I request and consent to the performance of physical examination and treatment on me or the patient names below for whom I am responsible by any licensed doctors or authorized providers in the office.

_______________________________________ ____________

Parent/ Guardian signature Date