

Welcome to our NUCCA Practice! We are very excited to help you create health in your life with NUCCA.

NUCCA is a process that starts with the initial visit. The goal of this visit is to determine how your bones are shaped, how they are misaligned, and to correct you to restore structural balance and level the pelvis. We welcome questions during all of your visits; however, if your question requires some research or a detailed answer, we will schedule a separate time to talk with you in person or by phone.

We are including a few forms for you to complete and bring with you on your first visit. Please complete them all prior to arriving for your initial visit. We need to spend the majority of the scheduled time frame examining your spine with posture analysis and taking accurate, NUCCA specific x-rays. The initial visit occurs in two parts:

Visit 1a: Health history and spinal evaluation (approximately 20 minutes)  
3 NUCCA specific x-ray views of your head and neck (approximately 1 - 1.5 hours)  
(sometimes x-rays need to be repeated in order to get the most accurate information and give you the best NUCCA correction possible)  
Marker measurement (approximately 5 minutes)

Visit 1b: Report of X-ray findings (approximately 10 minutes)  
Initial NUCCA correction and post spinal evaluation (approximately 20 minutes)  
Post NUCCA specific x-rays to make sure you are realigned properly. We may have to repeat the correction and post x-ray process as some people realign more easily and some take more effort. (approximately 30 minutes – 1 hour)  
Take home instructions (approximately 10 minutes)  
Marker measurement (approximately 5 minutes)

Between parts 1a and 1b the doctor will take 30 or more minutes to analyze your x-rays to determine how to correct you unique to your misalignment. You may schedule 1a and 1b on the same day or on different days. We encourage you to eat a meal before you come to the office and bring snacks with you as you are with us for a long period of time. We have a small refrigerator that you can use and we also provide bottled spring water. There are several restaurants within .5 miles of our office.

To expedite the initial visit, please wear a shirt with no collar, i.e. a T-shirt or scoop-necked shirt and dress comfortably. Also, please wear or bring a pair of shoes that cover your entire heel and that are flat or have a low heel. Please remove any jewelry that is on or near your head and neck before arriving. During the x-ray process, be prepared to remove dentures and removable dental appliances.

Lastly, please do not allow anyone to manipulate or massage your neck 4 days prior to your initial NUCCA visit. We need to x-ray your neck in a settled position to get accurate information and these treatments can cause the nerves and, therefore the muscles and joints to be active for 4 days.

Please sign the attached sheet confirming that you have read and understand the process and requirements of the first visit.

I have read the attached letter and understand the process and the requirements of the initial NUCCA visit at Body in Harmony, PC.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



Body in Harmony, PC  
11840 Nicholas St. Suite 102, Omaha, NE 68154

**Dr. Marcella Ziska**  
**Current History**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Case #: \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

What is the location of your chief complaint? \_\_\_\_\_

If you have pain, does it travel and to where? \_\_\_\_\_

When did this issue begin? Date of Onset: \_\_\_\_\_

What specific event brought it on? \_\_\_\_\_

Was its onset Sudden or Gradual? (please circle one)

Have you had anything like this before the above date? Dates/Event : \_\_\_\_\_

Since your symptoms started, have they Increased, Decreased or Stayed the Same? (please circle one if it applies)

Severity: Mild (0,1,2,3) Moderate(4,5,6) Severe (7,8,9,10)

(please put a number in each blank): Min: \_\_\_\_\_ Max: \_\_\_\_\_ Now: \_\_\_\_\_

Please describe your pain: Sharp, Dull, Burning, Ache, Throb, Tingling, or Other words you would use \_\_\_\_\_

Time: Does the pain occur all the time \_\_\_\_\_ or does it come and go \_\_\_\_\_?: (Check one)

Is the pain: **Better, Worse** in the **AM** compared to **Better, Worse** in the **PM**: or about the **Same** throughout the day? (circle appropriate choice)

If you have pain how long does it last when it occurs?: \_\_\_\_\_

What makes it better?: \_\_\_\_\_

What makes it worse?: \_\_\_\_\_

What other Doctors/Health Care Professionals have you seen for this problem?

\_\_\_\_\_

List medication you take for this condition: \_\_\_\_\_

List other medication/supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Last Physical Exam Date: \_\_\_\_\_ Blood Pressure History: high, low or normal (circle one)

Have you ever suffered from

- Alcoholism       Chest Pain/Conditions       Frequent Urination       Loss of Balance       Swollen Joints
- Allergies       Cold Extremities       Headache       Loss of taste       Tuberculosis
- Anemia       Constipation Cramps       Hemorrhoids       Neck Pain or Stiffness       Ulcers
- Arteriosclerosis       Depression       High Blood Pressure       Nervousness       Varicose Veins
- Arthritis       Diabetes       Hot Flashes       Pacemaker       Venereal Disease
- Asthma       Digestion Problems       Irregular Heart Be       Polio       Others \_\_\_\_\_
- Back Pain       Dizziness       Irregular Cycle       Poor Posture      \_\_\_\_\_
- Breast Lump       Ear Ringing       Kidney Infection       Prostate Trouble      \_\_\_\_\_
- Bronchitis       Excessive Menstruation       Kidney Stones       Sciatica      \_\_\_\_\_
- Bruise Easily       Eye Pain/Difficulties       Loss of Memory       Shortness of Breath      \_\_\_\_\_

Hospitalizations/Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Accidents (Falls/Auto) \_\_\_\_\_  
\_\_\_\_\_

Work Hours: \_\_\_\_\_/Wk      Sleep Hours: \_\_\_\_\_/Night      Exercise Hours: \_\_\_\_\_/Wk  
Type of Exercise: \_\_\_\_\_

Family Health History (Illnesses, Medications, Deaths)

Mom and her family: \_\_\_\_\_

Dad and his family: \_\_\_\_\_

Siblings: \_\_\_\_\_

Describe what you typically eat for: Brkfst \_\_\_\_\_ Lunch \_\_\_\_\_  
Supper \_\_\_\_\_ Snacks \_\_\_\_\_

What is your intake per day of: Caffeine \_\_\_\_\_ Tobacco \_\_\_\_\_ H2O oz. \_\_\_\_\_ Alcohol \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

A. Notifier: Body in Harmony, PC

B. Patient Name:

C. Identification Number:

---

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** Medicare may not reimburse for *the services listed* below.

Medicare does not reimburse for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not reimburse for *the services listed* below.

Services	Reason Medicare May Not Reimburse :	Estimated Cost
Examination X-rays Non spinal treatments or specific Complaints not approved by Medicare	Coverage is limited to correction of the spine by manual means and as deemed "medically necessary" per Medicare guidelines.	\$90 \$325 \$15-\$55

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **services** listed above.  
**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want *the services listed* above. You will ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want *the services listed* above, but do not bill Medicare. You will ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want *the services listed* above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Body in Harmony, PC

Dr. Marcella Ziska  
Lisa Garrett, MS, GCP  
11840 Nicholas St. Ste 102, Omaha, NE 68154  
Phone: (402) 614-4201 Fax: (402) 614-4520

**Authorization to Release Personal and Health Information**

Your personal information and health records at Body in Harmony, PC are completely confidential according to the current HIPAA regulations. In order for us to release any information, we require that you give us **written permission**. By signing this release, you are approving any release of information only to the insurance company that may reimburse for your care and/or to those you specifically write in below.

We are not a participating provider with any insurance company as we choose to be out-of-network. **You are responsible for all fees and agree to pay at the time of each service.** We will file with your insurance company as a courtesy and we request that your insurance company reimburse you directly for any out of network benefits you are due. Insurance companies may or may not reimburse you for any services received in this office on any visit. We do not submit to Medicare as we offer maintenance/wellness care only. Medicare will not reimburse for this type of care.

A copy of this form is available upon request.

**Please complete if you allow us to share personal and health information with a specific member of your family, partner, friend, insurance company or health care provider.**

Insurance Co Name \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

(For additional space, you may use the back of this page.)

**You give us permission to thank the person who referred you to Body in Harmony, PC.**

Name of Referral Source \_\_\_\_\_

**You give us permission to communicate with you in the following ways:**

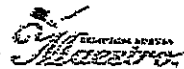
Text \_\_\_\_\_ Cell phone voicemail \_\_\_\_\_

Home phone voicemail \_\_\_\_\_ Work voicemail \_\_\_\_\_

Leave message with family member \_\_\_\_\_ Email \_\_\_\_\_

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_ Case # \_\_\_\_\_

# SYMPTOM SURVEY FORM



Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Approx Weight \_\_\_\_\_ Sex: Male  Female   
 Pulse: Recumbent \_\_\_\_\_ Standing \_\_\_\_\_ Vegetarian: Yes  No   
 Blood pressure: Recumbent \_\_\_\_/\_\_\_\_ Standing \_\_\_\_/\_\_\_\_ Ragland's Test is Positive

**INSTRUCTIONS:** Fill in only the circles which apply to you.  
 ● ○ ○ MILD symptoms (occurred once or twice last 6 months).  
 ○ ● ○ MODERATE symptoms (occurred once or twice last month).  
 ○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).  
 ○ ○ ○ Leave circles BLANK if they don't apply to you!

- 1 2 3 GROUP 1
- 1 ○ ○ ○ Acid foods upset
  - 2 ○ ○ ○ Get chilled often
  - 3 ○ ○ ○ "Lump" in throat
  - 4 ○ ○ ○ Dry mouth-eyes-nose
  - 5 ○ ○ ○ Pulse speeds after meal
  - 6 ○ ○ ○ Keyed up - fail to calm
  - 7 ○ ○ ○ Cut heals slowly
  - 8 ○ ○ ○ Gag easily
  - 9 ○ ○ ○ Unable to relax; startles easily
  - 10 ○ ○ ○ Extremities cold, clammy
  - 11 ○ ○ ○ Strong light irritates
  - 12 ○ ○ ○ Urine amount reduced
  - 13 ○ ○ ○ Heart pounds after retiring
  - 14 ○ ○ ○ "Nervous" stomach
  - 15 ○ ○ ○ Appetite reduced
  - 16 ○ ○ ○ Cold sweats often
  - 17 ○ ○ ○ Fever easily raised
  - 18 ○ ○ ○ Neuralgia-like pains
  - 19 ○ ○ ○ Staring, blinks little
  - 20 ○ ○ ○ Sour stomach often
- GROUP 2
- 21 ○ ○ ○ Joint stiffness on arising
  - 22 ○ ○ ○ Muscle-leg-toe cramps at night
  - 23 ○ ○ ○ "Butterfly" stomach, cramps
  - 24 ○ ○ ○ Eyes or nose watery
  - 25 ○ ○ ○ Eyes blink often
  - 26 ○ ○ ○ Eyelids swollen, puffy
  - 27 ○ ○ ○ Indigestion soon after meals
  - 28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
  - 29 ○ ○ ○ Digestion rapid
  - 30 ○ ○ ○ Vomiting frequent
  - 31 ○ ○ ○ Hoarseness frequent
  - 32 ○ ○ ○ Breathing irregular
  - 33 ○ ○ ○ Pulse slow; feels "irregular"
  - 34 ○ ○ ○ Gagging reflex slow
  - 35 ○ ○ ○ Difficulty swallowing
  - 36 ○ ○ ○ Constipation, diarrhea alternating
  - 37 ○ ○ ○ "Slow starter"
  - 38 ○ ○ ○ Get "chilled" infrequently
  - 39 ○ ○ ○ Perspire easily
  - 40 ○ ○ ○ Circulation poor, sensitive to cold
  - 41 ○ ○ ○ Subject to colds, asthma, bronchitis
- GROUP 3
- 42 ○ ○ ○ Eat when nervous
  - 43 ○ ○ ○ Excessive appetite
  - 44 ○ ○ ○ Hungry between meals
  - 45 ○ ○ ○ Irritable before meals
  - 46 ○ ○ ○ Get "shaky" if hungry
  - 47 ○ ○ ○ Fatigue, eating relieves
  - 48 ○ ○ ○ "Lightheaded" if meals delayed
  - 49 ○ ○ ○ Heart palpitates if meals missed or delayed
  - 50 ○ ○ ○ Afternoon headaches
  - 51 ○ ○ ○ Overeating sweets upsets

- 1 2 3
- 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
  - 53 ○ ○ ○ Crave candy or coffee in afternoons
  - 54 ○ ○ ○ Moods of depression - "blues" or melancholy
  - 55 ○ ○ ○ Abnormal craving for sweets or snacks
- GROUP 4
- 56 ○ ○ ○ Hands and feet go to sleep easily, numbness
  - 57 ○ ○ ○ Sigh frequently, "air hunger"
  - 58 ○ ○ ○ Aware of "breathing heavily"
  - 59 ○ ○ ○ High altitude discomfort
  - 60 ○ ○ ○ Opens windows in closed rooms
  - 61 ○ ○ ○ Susceptible to colds and fevers
  - 62 ○ ○ ○ Afternoon, "yawner"
  - 63 ○ ○ ○ Get "drowsy" often
  - 64 ○ ○ ○ Swollen ankles, worse at night
  - 65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
  - 66 ○ ○ ○ Shortness of breath on exertion
  - 67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
  - 68 ○ ○ ○ Bruise easily, "black and blue" spots
  - 69 ○ ○ ○ Tendency to anemia
  - 70 ○ ○ ○ "Nose bleeds" frequent
  - 71 ○ ○ ○ Noises in head, or "ringing in ears"
  - 72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion
- GROUP 5
- 73 ○ ○ ○ Dizziness
  - 74 ○ ○ ○ Dry skin
  - 75 ○ ○ ○ Burning feet
  - 76 ○ ○ ○ Blurred vision
  - 77 ○ ○ ○ Itching skin and feet
  - 78 ○ ○ ○ Excessive falling hair
  - 79 ○ ○ ○ Frequent skin rashes
  - 80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
  - 81 ○ ○ ○ Bowel movements painful or difficult
  - 82 ○ ○ ○ Worrier, feels insecure
  - 83 ○ ○ ○ Feeling queasy; headache over eyes
  - 84 ○ ○ ○ Greasy foods upset
  - 85 ○ ○ ○ Stools light colored
  - 86 ○ ○ ○ Skin peels on foot soles
  - 87 ○ ○ ○ Pain between shoulder blades
  - 88 ○ ○ ○ Use laxatives
  - 89 ○ ○ ○ Stools alternate from soft to watery
  - 90 ○ ○ ○ History of gallbladder attacks or gallstones
  - 91 ○ ○ ○ Sneezing attacks
  - 92 ○ ○ ○ Dreaming, nightmare type bad dreams
  - 93 ○ ○ ○ Bad breath (halitosis)
  - 94 ○ ○ ○ Milk products cause distress
  - 95 ○ ○ ○ Sensitive to hot weather
  - 96 ○ ○ ○ Burning or itching anus
  - 97 ○ ○ ○ Crave sweets
- GROUP 6
- 98 ○ ○ ○ Loss of taste for meat
  - 99 ○ ○ ○ Lower bowel gas several hours after eating
  - 100 ○ ○ ○ Burning stomach sensations, eating relieves
  - 101 ○ ○ ○ Coated tongue
  - 102 ○ ○ ○ Pass large amounts of foul-smelling gas
  - 103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
  - 104 ○ ○ ○ Mucous colitis or "irritable bowel"
  - 105 ○ ○ ○ Gas shortly after eating
  - 106 ○ ○ ○ Stomach "bloating" after eating

1 2 3 GROUP 7A

- 107 ○ ○ ○ Insomnia
- 108 ○ ○ ○ Nervousness
- 109 ○ ○ ○ Can't gain weight
- 110 ○ ○ ○ Intolerance to heat
- 111 ○ ○ ○ Highly emotional
- 112 ○ ○ ○ Flush easily
- 113 ○ ○ ○ Night sweats
- 114 ○ ○ ○ Thin, moist skin
- 115 ○ ○ ○ Inward trembling
- 116 ○ ○ ○ Heart palpitates
- 117 ○ ○ ○ Increased appetite without weight gain
- 118 ○ ○ ○ Pulse fast at rest
- 119 ○ ○ ○ Eyelids and face twitch
- 120 ○ ○ ○ Irritable and restless
- 121 ○ ○ ○ Can't work under pressure

GROUP 7B

- 122 ○ ○ ○ Increase in weight
- 123 ○ ○ ○ Decrease in appetite
- 124 ○ ○ ○ Fatigue easily
- 125 ○ ○ ○ Ringing in ears
- 126 ○ ○ ○ Sleepy during day
- 127 ○ ○ ○ Sensitive to cold
- 128 ○ ○ ○ Dry or scaly skin
- 129 ○ ○ ○ Constipation
- 130 ○ ○ ○ Mental sluggishness
- 131 ○ ○ ○ Hair coarse, falls out
- 132 ○ ○ ○ Headaches upon arising, wear off during day
- 133 ○ ○ ○ Slow pulse, below 65
- 134 ○ ○ ○ Frequency of urination
- 135 ○ ○ ○ Impaired hearing
- 136 ○ ○ ○ Reduced initiative

GROUP 7C

- 137 ○ ○ ○ Failing memory
- 138 ○ ○ ○ Low blood pressure
- 139 ○ ○ ○ Increased sex drive
- 140 ○ ○ ○ Headaches, "splitting or rending" type
- 141 ○ ○ ○ Decreased sugar tolerance

GROUP 7D

- 142 ○ ○ ○ Abnormal thirst
- 143 ○ ○ ○ Bloating of abdomen
- 144 ○ ○ ○ Weight gain around hips or waist
- 145 ○ ○ ○ Sex drive reduced or lacking
- 146 ○ ○ ○ Tendency to ulcers, colitis
- 147 ○ ○ ○ Increased sugar tolerance
- 148 ○ ○ ○ Women: menstrual disorders
- 149 ○ ○ ○ Young girls: lack of menstrual function

GROUP 7E

- 150 ○ ○ ○ Dizziness
- 151 ○ ○ ○ Headaches
- 152 ○ ○ ○ Hot flashes
- 153 ○ ○ ○ Increased blood pressure
- 154 ○ ○ ○ Hair growth on face or body (female)
- 155 ○ ○ ○ Sugar in urine (not diabetes)
- 156 ○ ○ ○ Masculine tendencies (female)

GROUP 7F

- 157 ○ ○ ○ Weakness, dizziness
- 158 ○ ○ ○ Chronic fatigue
- 159 ○ ○ ○ Low blood pressure
- 160 ○ ○ ○ Nails weak, ridged
- 161 ○ ○ ○ Tendency to hives
- 162 ○ ○ ○ Arthritic tendencies
- 163 ○ ○ ○ Perspiration increase
- 164 ○ ○ ○ Bowel disorders
- 165 ○ ○ ○ Poor circulation
- 166 ○ ○ ○ Swollen ankles
- 167 ○ ○ ○ Crave salt
- 168 ○ ○ ○ Brown spots or bronzing of skin
- 169 ○ ○ ○ Allergies - tendency to asthma

1 2 3

- 170 ○ ○ ○ Weakness after colds, influenza
- 171 ○ ○ ○ Exhaustion - muscular and nervous
- 172 ○ ○ ○ Respiratory disorders

GROUP 8

- 173 ○ ○ ○ Apprehension
- 174 ○ ○ ○ Irritability
- 175 ○ ○ ○ Morbid fears
- 176 ○ ○ ○ Never seems to get well
- 177 ○ ○ ○ Forgetfulness
- 178 ○ ○ ○ Indigestion
- 179 ○ ○ ○ Poor appetite
- 180 ○ ○ ○ Craving for sweets
- 181 ○ ○ ○ Muscular soreness
- 182 ○ ○ ○ Depression; feelings of dread
- 183 ○ ○ ○ Noise sensitivity
- 184 ○ ○ ○ Acoustic hallucinations
- 185 ○ ○ ○ Tendency to cry without reason
- 186 ○ ○ ○ Hair is coarse and/or thinning
- 187 ○ ○ ○ Weakness
- 188 ○ ○ ○ Fatigue
- 189 ○ ○ ○ Skin sensitive to touch
- 190 ○ ○ ○ Tendency toward hives
- 191 ○ ○ ○ Nervousness
- 192 ○ ○ ○ Headache
- 193 ○ ○ ○ Insomnia
- 194 ○ ○ ○ Anxiety
- 195 ○ ○ ○ Anorexia
- 196 ○ ○ ○ Inability to concentrate; confusion
- 197 ○ ○ ○ Frequent stuffy nose; sinus infections
- 198 ○ ○ ○ Allergy to some foods
- 199 ○ ○ ○ Loose joints

FEMALE ONLY

- 200 ○ ○ ○ Very easily fatigued
- 201 ○ ○ ○ Premenstrual tension
- 202 ○ ○ ○ Painful menses
- 203 ○ ○ ○ Depressed feelings before menstruation
- 204 ○ ○ ○ Menstruation excessive and prolonged
- 205 ○ ○ ○ Painful breasts
- 206 ○ ○ ○ Menstruate too frequently
- 207 ○ ○ ○ Vaginal discharge
- 208 ○ Hysterectomy / ovaries removed
- 209 ○ ○ ○ Menopausal hot flashes
- 210 ○ ○ ○ Menses scanty or missed
- 211 ○ ○ ○ Acne, worse at menses
- 212 ○ ○ ○ Depression of long standing

MALE ONLY

- 213 ○ ○ ○ Prostate trouble
- 214 ○ ○ ○ Urination difficult or dribbling
- 215 ○ ○ ○ Night urination frequent
- 216 ○ ○ ○ Depression
- 217 ○ ○ ○ Pain on inside of legs or heels
- 218 ○ ○ ○ Feeling of incomplete bowel evacuation
- 219 ○ ○ ○ Lack of energy
- 220 ○ ○ ○ Migrating aches and pains
- 221 ○ ○ ○ Tire too easily
- 222 ○ ○ ○ Avoids activity
- 223 ○ ○ ○ Leg nervousness at night
- 224 ○ ○ ○ Diminished sex drive

List the five main complaints you have in the order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_



Body in Harmony, PC  
11840 Nicholas St. Suite 102, Omaha, NE 68154  
Dr. Marcella Ziska

#### INFORMED CONSENT UNDER NEBRASKA CODE SECTION 44-2816

Body in Harmony, PC, is a Corporation operated by Dr. Marcella Ziska.

Chiropractic is a philosophy, art and science which concerns itself with the relationship between structure, primarily the spine, and function, primarily of the nervous system. This relationship may affect the restoration and preservation of health, however, **it is not our intention to either diagnose or treat a medical condition.** The job of this practice is to identify, reduce and correct the Atlas Subluxation Complex. (Subluxation is described in the next paragraph.) The practice of chiropractic includes many standard examination and testing procedures. This office may utilize some of those procedures for the purpose of documenting the probable presence or absence of a subluxation. These may include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiology examinations. Physiotherapy and rehabilitation procedures may also be utilized to enhance the healing and/or retaining of certain tissues of the body. Unique to the chiropractic profession is the spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae are misaligned sufficiently to alter biomechanical motion and cause interference to the nervous system. The primary goal in chiropractic health care is the removal of nerve interference by reducing or eliminating the subluxation.

There are a number of different adjusting techniques we may use in this office. NUCCA will be the primary technique. NUCCA adjustments are performed by hand, generating a non-thrusting force delivered to a specific contact point, in a highly specific manner for the **purpose of reducing and/or eliminating the Atlas Subluxation Complex and helping to level the pelvis and restore body balance.** Other thrusting or non-thrusting adjustments may be utilized by hand or by a hand-guided instrument to joint complexes other than the upper cervical area, to improve biomechanical relationships and remove subluxations as indicated.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware that like all health care procedures, there are some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including stroke, resulting in brain damage or perhaps death through complicating factors.

If you have any questions concerning the information provided, please notify the doctor prior to care, and obtain the necessary information to make the best decision about receiving chiropractic care.

#### AUTHORIZATION FOR CHIROPRACTIC CARE

I have read the above paragraphs and understand the information provided. I have been informed of the nature and purpose of chiropractic care, the possible consequences of that care, the risks of that care, including the risk that chiropractic care may not accomplish the desired objective and the possible risk of receiving no chiropractic care. I acknowledge that no guarantees have been made to me concerning the results of care and treatment. All questions which I have asked have been answered to my satisfaction. Having this knowledge, I knowingly authorize Dr. Ziska of Body in Harmony, PC to proceed with chiropractic care and allow them to share my x-rays with their NUCCA Board Certified doctors/coaches in their pursuit of NUCCA board certification.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLIENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
CASE#

\_\_\_\_\_  
DOCTOR SIGNATURE



Body in Harmony, PC  
11840 Nicholas St. Suite 102, Omaha, NE 68154

Dr. Marcella Ziska

### Contact Information

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ Nickname: \_\_\_\_\_

Suffix \_\_\_\_\_ Sex: M or F (circle one) Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Salutation: Mr., Mrs., Miss., Ms., (circle one) Name of Spouse \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Email: \_\_\_\_\_ Last 4 of SS# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Doctor \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Previous Chiropractic: Yes \_\_\_\_\_ or No \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

**If a Minor: Person responsible:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M or F

Relationship to patient \_\_\_\_\_

Address if different from above: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Check box if you would like to share Medical Information with this person.

---

What do you expect from receiving your spinal correction at Body in Harmony Chiropractic Center, PC?

Short Term Goals: \_\_\_\_\_

Long Term Goals: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

Case # \_\_\_\_\_