WELCOME

Our office is an expression of vibrational healing and vibrant wellness.

We recognize that as we integrate and wake-up in our bodies, exposure to certain chemicals in our environment may be harmful to our systems. We please ask that you refrain from wearing colognes, perfumes, body lotions and sprays, lacquers of any kind that give off strong smells and odors when visiting our office.

Please turn all cell phones off before entering.

Please enter entrainment room quietly to allow everyone present to have their sacred experience without disrupting noise while placing personal items in baskets under the table.

Welcome to Transforming your life.
Achieving levels of Vitality you didn't know were possible.
It is a joy to have you participate in our practice.

Sincerely,
Dr. Michael Whelan's Office

Michael Whelan, D.C.

Network Spinal Analysis
25431 Cabot Rd. #205 Laguna Hills, CA 92653 (949) 581-5231
www.VitalisticHealingArtsCenter.com

Dear Practice Member,
Welcome to our office and thank you for considering us in your quest for optimal health. In our space we provide a tranquil environment that allows you to dive deep into your internal healing space. By bypassing the habituated active mind and the hyper vigilant state, your nervous system is able to deeply connect to your energy fields, physical body and emotional self in order to reconnect, reset, recalibrate and reestablish a novel, more coherent and more energy efficient you. Network Spinal Analysis is an inner Technology that Optimizes your spine and nervous system. Research has shown people receiving Network Care significantly improve their quality of life.

Attached you will find these documents:

- Statement of Purpose
- Health History
- Insurance and Informed Consent

Please read and complete this information prior to your visit. We look forward to meeting you.

Warmest Regards,
Michael Whelan, D.C.

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 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 the interference, creating greater communication between your mind, body and life, thus promoting better health, vitality and sense of well-being. 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 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 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 accomodate 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. Michael Whelan

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, Zero Balancing, Zyto Evox, Bemer Technology, Infrared Sauna and specific chiropractic adjustments to promote the natural mechanisms for self-healing and empowerment.

Signature:____________________________________ Date: ______________________

Health History

Name____ Date__________________

Address______________________________ City_______________ Zip Code____________

Phone (H)___________________________ (C)___________________(O)_______________

Email ___________________________________ Referred By_________________________

Date of Birth___________________ Age__________ Height_________ Weight___________

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?____
4. Have you had 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 3 months? Yes No
7. What was the reason for your visit?____
8. What was done or suggested?____
9. Please list drugs, when prescribed and reason.

   ____

10. Do you have an exercise, meditation, prayer, nutritional or dietary program?

    ____

11. Have you ever injured your spine (neck, 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 parts 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. What age do you want to live?____

15. How much do you value your health?____

16. When stressed how do you center or regroup yourself? ______________________________

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

18. Are there any particular factors in 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. How do you rate your physical health?____

20. How do you rate your emotional/mental health?_____________________________________

21. Are you addicted to anything? (alcohol, sugar, caffeine, adrenalin, etc.)__________________

22. What is the main purpose of your visit today?______________________________________

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

24. Is there anything else you wish to share that may help us to better understand you and why you have chosen to be seen by Dr. Whelan?____

    ____

Insurance Assignment & Release of Information and Authorization

I, the undersigned, certify that I (or my dependent(s)) have insurance coverage and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. If my insurance requires a referral and I receive care without proper authorization, I understand I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of my benefits and to authorize the use of this signature on all insurance submissions. A copy of this document shall be considered as valid as the original.

Parent/Guardian Signature ______________________ Date ______________

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.

Print Patient(s) Name ______________________________________

Parent/Guardian Signature ______________________ Date ______________