

TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:

The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:

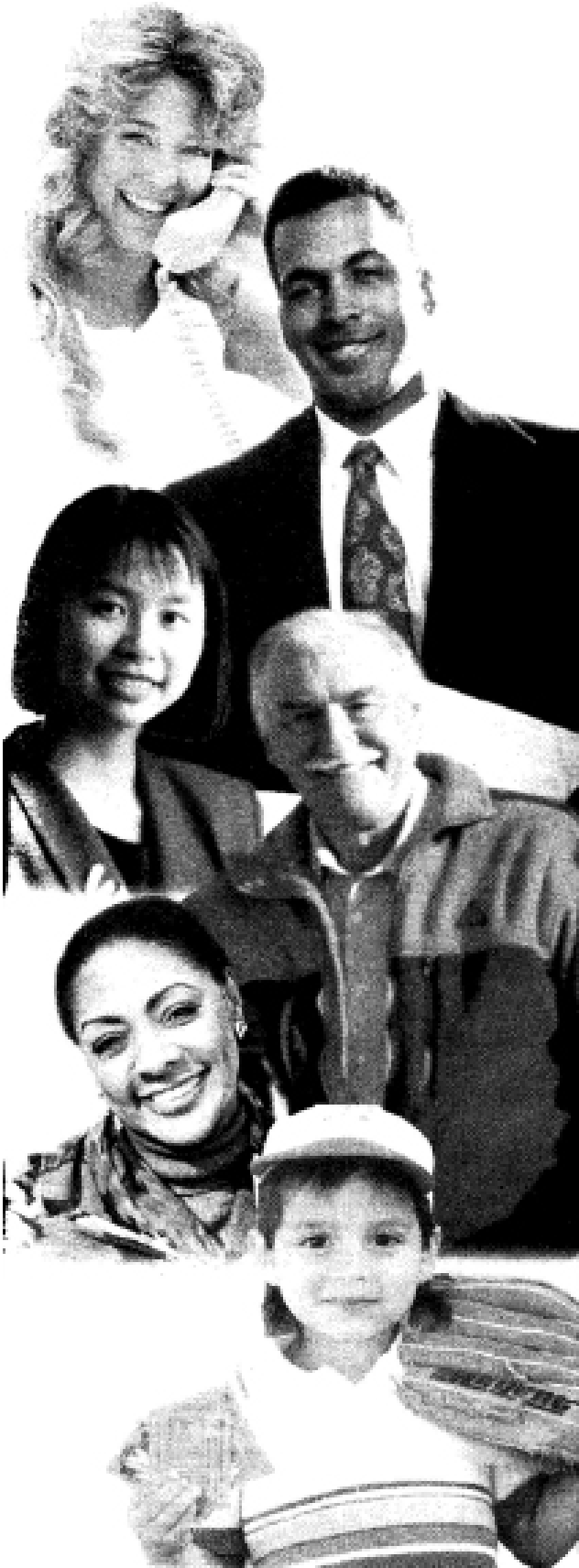
If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.



Confidential Patient Health Record

DATE	ID No.
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Personal History

Name:	Home Phone:
Address:	Cell Phone:
City:	Email Address:
State:	Birth Date: Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Zip Code:	Circle One: Single Married Widowed Divorced Separated
Your Driver's License Number:	Spouse's Name:
Your Social Security Number:	Spouse's Social Security Number:
Your Employer:	Spouse's Employer:
Your Business Phone:	Spouse's Business Phone:
Your Type of Work:	Spouse's Type of Work:
Emergency Contact Name: Phone Number: Relationship:	Names and Ages of Children:
Who referred you to this office?	
Who is responsible for your bill? You and: <input type="checkbox"/> Spouse <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Car Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	
Personal Health Insurance (Name):	Health Card #
Insured Person's Name:	Insured Person's Date of Birth:

Current Health Condition

Unwanted Health Condition:	
Other doctors seen for this condition: <input type="checkbox"/> No <input type="checkbox"/> Yes—Who?	
Type of Treatment:	Results:
When did this condition begin?	Has this condition occurred before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is condition due to: <input type="checkbox"/> Injury at home <input type="checkbox"/> Injury at your job <input type="checkbox"/> Car accident <input type="checkbox"/> Fall <input type="checkbox"/> Other (explain):	
Date of Accident:	Time of Accident:
If the accident happened at your job, have you reported the accident to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drugs you now take: <input type="checkbox"/> Nerve pills <input type="checkbox"/> Painkillers <input type="checkbox"/> Muscle Relaxers <input type="checkbox"/> Insulin <input type="checkbox"/> Blood Pressure Medicine <input type="checkbox"/> Other (list):	
Do you wear a shoe lift? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you suffer from any condition other than that for which you are now consulting us?	

Past Health History

Major Surgery/Operations: <input type="checkbox"/> Appendectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hernia <input type="checkbox"/> Back Surgery <input type="checkbox"/> Broken Bones <input type="checkbox"/> Other (explain):
Major accidents or falls (explain):
Hospitalization (other than above):
Previous chiropractic care: <input type="checkbox"/> None <input type="checkbox"/> Doctor's name & approximate date of last visit:

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check Any of the Following Diseases You Have Had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Eczema |

Check If You Use:

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

Check Any of the Following You Have Had in the Past Six Months:

Musculo-Skeletal

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficulty chewing/clicking jaw
- General stiffness

- Weight trouble
- Abdominal cramps
- Gas/bloating after meals
- Heartburn
- Black/bloody stool
- Colitis

Females Only

When was your last period?

Are you pregnant?

- Yes No Not sure

Nervous System

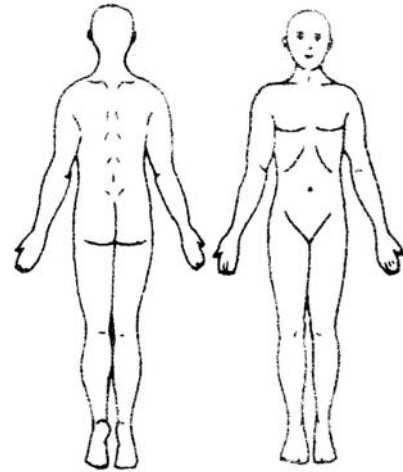
- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/depression
- Fainting
- Convulsions
- Cold/tingling extremities
- Stress

Urinary

- Bladder trouble
- Painful/excessive urination
- Discolored urine

Cardio-Vascular/Respiratory

- Chest pain
- Shortness of breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems/congestion
- Varicose veins
- Ankle swelling
- Stroke



Please circle on the diagram the areas of your discomfort.

General

- Fatigue
- Allergies
- Loss of sleep
- Fever
- Headaches

Eye/Ear/Nose/Throat

- Vision problems
- Dental problems
- Sore throat
- Earaches
- Hearing difficult
- Stuffy nose

Gastro-Intestinal

- Poor/excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gallbladder problems

Reproductive

- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/infection
- Breast pain/lumps
- Prostate/sexual dysfunction
- Other problems
- _____
- _____
- _____

Family History

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature

Most patients who come to our office have one of two objectives in mind concerning their healthcare. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care Check here if you want the doctor to select the type of care appropriate for your condition.
 Corrective Care

Patient Signature: _____ Date: _____

If this is an accident-related injury, please fill out the Accident Form. Thank you!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective Care differs from Relief Care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting.

I understand and agree that health and accident insurances policies are an arrangement between an insurance carrier and myself. Further more, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as he or she deems appropriate. It is understood and agreed that the amount paid to the doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am a patient of this office. I also agree that I am responsible for all bills incurred at this office.

Patient Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care: _____ Date: _____

