



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.

PERSONAL HISTORY

Name: _____ Address: _____
 City: _____ State/Prov: _____ Zip/Postal Code: _____
 Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
 Social Security # _____ Driver's License Number: _____
 Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated
 Business Employer: _____ Type of Work: _____
 Business Phone: _____ Spouse's Social Security # _____
 Name of Spouse _____ Spouse's Social Insurance # _____
 Spouse's Employer _____ Business Phone _____
 Type of Work _____ Name and Ages of Children _____
 Referred To This Office By: _____ Email Address _____
 Name and Number of Emergency Contact: _____ Relationship: _____
 Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____
 Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
 Other Doctors Seen For This Condition: Yes No _____ Who? _____
 Type of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
 Date of Accident: _____ Time of Accident: _____
 Have You Made A Report of Your Accident To Your Employer: Yes No
 Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other _____
 Do You Wear A Shoe Lift? Yes No
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
 Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
 Major Accident or Falls: _____
 Hospitalization (Other Than Above): _____
 Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which 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"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <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 | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

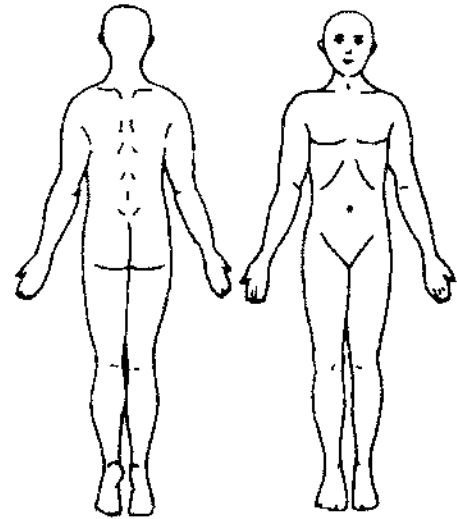
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

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 that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the problem 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

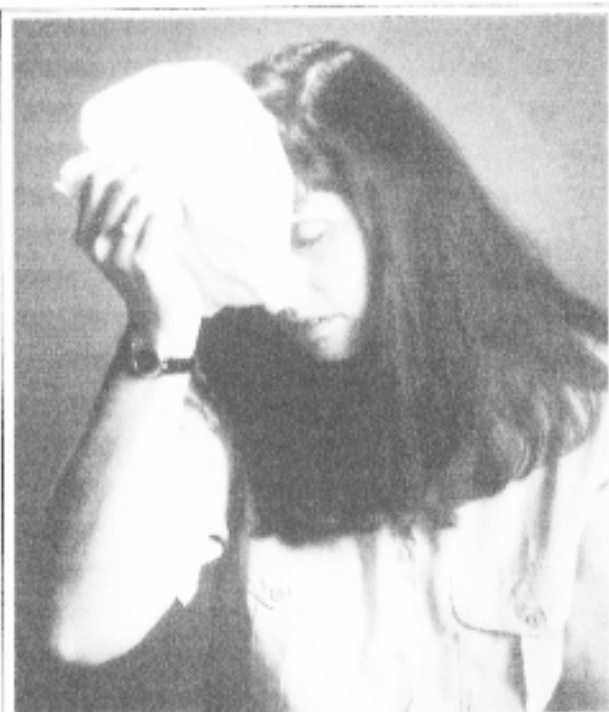
Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date _____

Patient's Signature _____

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 insurance policies are an arrangement between an insurance carrier and myself. Furthermore, 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 the 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 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 my insurance, the balance of my account 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 the amount paid the Doctor, 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 at this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date _____

Consent to Treat a Minor _____

Date _____

Guardian or Spouse's
Signature of Authorizing Care _____

Date _____