TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this health history questionare

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss what the underlying cause may be.

STEP THREE:
A comprehensive functional 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:
The doctor will review the findings with you at which time the cause of your problem will be discussed. This includes a thorough explanation of exam findings, lab tests, x-rays, how treatment works, and what results can be obtained.

STEP SIX:
When the doctor accepts your case, you will be given a personal recommendation for care. Upon your acceptance, you will be advised concerning how our office procedures work. Treatment will then begin and will continue until you reach Maximum Functional Improvment.

STEP SEVEN:
After maximum functional improvement has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Confidential Health Record

Date

PERSONAL HISTORY

Name:_____ Birth Date:_____ Age:_____ Sex: ☐ M ☐ F

Social Security #:_____ Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Email Address:_____

Employer:_____ Type of Work:_____

Business Phone:_____

Name of Spouse:_____ Spouse's Employer:_____

Spouse's Business Phone:_____ Type of Work:_____

Name and Age of Children:_____

Emergency Contact:_____ Phone:_____

Relationship:_____ Referred to This Office By:_____

Who Is Responsible For Your Bill, You and: ☐ Spouse ☐ Workers' Comp. ☐ Auto Ins. ☐ Medicare ☐ Medicaid

Health Insurance Co.:_____ Insured Person's Name:_____

Date of Birth: _____ Address of Insured:_____

CURRENT HEALTH CONDITION(S)

Current Health Concern(s):_____

Other Doctor(s) Seen For This Condition? ☐ Yes ☐ No Who?_____

Type of Treatment:_____ Results:_____

When Did This Condition Begin?_____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is the Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other:_____

Date of Accident:_____ Time of Accident:_____

Have You Made A Report of The Accident To Your Employer/Insurance? ☐ Yes ☐ No If Yes, Claim #_____

Drugs Currently Taking: ☐ Depression ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure ☐ Cholesterol

Other:_____

Do You Wear A Shoe Lift or Orthotics? ☐ Yes ☐ No

Do You Suffer From Any Other Health Condition?_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other:_____

Major Accidents or Falls:_____

_____

Hospitalizations (Other Than Above):_____

_____

Previous Chiropractic Care? ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

_____

Below is 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:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Hyper/Hypo Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes

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

MUSCULOSKELETAL CODE

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

NERVOUS SYSTEM CODE

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

GASTROINTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITOURINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Asthma

EENT CODE

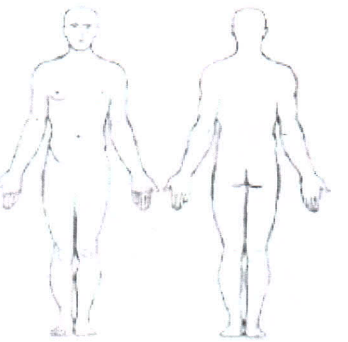
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Sinus Issues

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Fever
- ☐ Headaches
- ☐ Other _____



Please outline on the diagram the area(s) of your discomfort.

FAMILY HISTORY

The following members have a same or similar condition as I do.

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

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

ANALYSIS:

DIAGNOSIS:

DO NOT WRITE BELOW THIS LINE

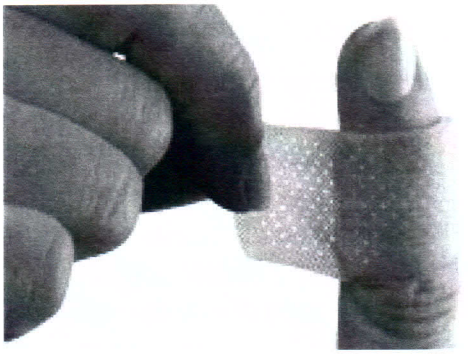
Patient Accepeted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

Functional Healthcare VS Traditional Healthcare

Our main objective is to restore function to your body in order to create a long term solution for your health, we call this **Functional Healthcare**. In **Traditional Healthcare** the objective is often short term relief that requires continual treatment, like taking a blood pressure medication to continually lower blood pressure instead of addressing the problem of why the blood pressure is high. Traditional Healthcare may be needed in emergency situations, however it does not always correct the underlying problem. In Functional Healthcare we are interested in correcting the function of the body resulting in a measurable, lasting solution.



TRADITIONAL HEALTH CARE

Traditional Healthcare has an objective of relieving symptoms, 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.

FUNCTIONAL HEALTH CARE

Functional Healthcare differs from Traditional Healthcare in that its goal is to get rid of the symptoms by addressing the cause. Functional Healthcare creates a lasting result.

I understand and agree that health and accident insurance policies are an agreement 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 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, 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 the amount paid 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 a patient of 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 Minor _____ *Date*_____

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