TO THE NEW PATIENT

Outline of Procedure for New Patients

1. **STEP ONE:**
   All new patients are requested to fill out a personal health/history questionaire.

2. **STEP TWO:**
   Your first consultation with the doctor to discuss your health problems.

3. **STEP THREE:**
   Chiropractic examination and Orthopedic and Neurological examinations are related to chiropractic to determine chiropractic care for you.

4. **STEP FOUR:**
   The doctor will advise you as to the need of additional procedures such a X-ray tests, if necessary.

5. **STEP FIVE:**
   You will be given a ***"Report of Findings"*** on your second scheduled visit. The doctor will inform you as to your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. **STEP SIX:**
   After you receive your report of findings, your recommended course of care will be explained to you.

7. **STEP SEVEN:**
   Adjustments will begin and continue as scheduled until maximum correction for you has been obtained.

8. **STEP EIGHT:**
   After maximum correction, a schedule of care will be recommended.

PERSONAL HISTORY

Date:_____ Case Number:_____

Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Business Phone:_____

Cell Phone:_____ E-Mail Address:_____

Birth Date:_____ Age:_____ Sex: M F Height:_____ Weight:_____

Business/Employer:_____ Type of Work:_____

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

SS#_____ Spouse's SS#_____ # of Children_____

Referred to this office by:_____

Who is responsible for your bill, You and: □ Spouse □ Workman's Compensation □ Medicare □ Auto Insurance

□ Personal Health Insurance □ Other_____

CURRENT HEALTH CONDITION

Purpose of this appointment:_____

Major Complaint:_____

Other Doctor's seen for this condition:_____

When did this condition begin:_____

Are there others in your family with this same or similar condition:_____

_____

_____

If disabled from work please give dates:_____

□ Job Related □ Auto Related □ Date of Accident/Injury_____

Current Medications: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure □ Insulin □ Anti-depressants
□ Cholesterol □ Aspirin/Similar □ ADD/ADHD □ Over the Counter □ Other Prescriptions

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PAST HEALTH HISTORY

Please check or describe

Major Surgery/Operations: □ Appendix □ Tonsils □ Gall Bladder □ Hernia □ Heart □ Back □ Neck □ Leg

□ Other_____

Major Accidents or Falls:_____

Hospitalization (Other than above)_____

Previous Chiropractic Care: Doctor's name and approximate date of last visit:_____

_____

Have you been treated for any health condition in the last year? Y N

If yes, please explain:_____

_____

Below are lists 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 chiropractic 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
- □ Thyroid
- □ Influenza
- □ Pleurisy
- □ Arthritis
- □ Epilepsy
- □ Mental Disorder
- □ Lumbago
- □ Eczema

INTAKE

- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ White Sugar
- □ Daily Aspirin

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
- □ Diffcult Chewing/Clicking jaw
- □ General Stiffness

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

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

- □ Gas/Bloating After Meals
- □ Heartburn
- □ Black/Bloody stool
- □ Colitis

GENITO-URINARY CODE

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

C-V-R CODE

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

EENT CODE

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

MALE/FEMALE CODE

- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vaginal Pain/Infections
- □ Breast Pain/Lumps
- □ Prostrate/Sexual Dysfunction

OTHER

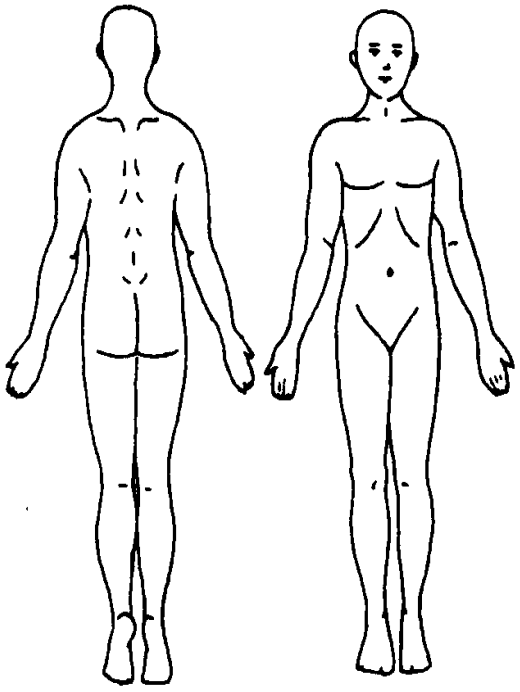
- □ AIDS
- □ Hepatitis
- □ ADD/ADHD

FEMALES ONLY:

When was your last period? _____

- □ Breast Inplants

Are you Pregnant? Y N Not Sure



Please outline on the diagram the area of discomfort.

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

_____

Doctor's Signature

Why Chiropractic? People go to the Chiropractors for a variety of reasons. Some go 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). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases.

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

□ Relief Care □ Corrective Care □ Preventative 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!

THE PURPOSE OF

OUR CHIROPRACTIC OFFICE

IS TO SUPPORT

EACH INDIVIDUAL

IN ACHIEVING THEIR

OPTIMUM HEALTH

AND TO

EDUCATE THEM

SO THAT THEY MAY

UNDERSTAND HEALTH

AND CHIROPRACTIC

AND IN TURN EDUCATE

OTHERS.

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 and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature **X**_____ SS#_____ Date_____

Guardian or Spouse's
Signature Authorizing Care_____ Date _____