THE TRIUNE OF HEALTH

YOUR HISTORY — OUR TREATMENT

- As a new patient, you will be requested to fill out a personal health/history questionnaire.
- Next, you will consult with one of our doctors to discuss your health issues.
- A physical examination, along with orthopedic and neurological examinations, follow to help determine the proper treatment for you.
- The doctor will then advise you as to the need for any additional procedures such as X-rays, blood work, etc., if necessary.
- You will be given a “Report of Findings” over your next 3 visits. At that time, the doctor will thoroughly explain to you the cause of your problem, why it will not go away on its own, treatment necessary, how long it will take and the fees involved. You will also be advised how our office procedures work.
- Once you understand your “Report of Findings” and how treatment works, we will give you options to improve your condition(s).
- Moving forward, treatments will then begin and continue as scheduled until maximum correction for you has been achieved.
- After maximum correction, a schedule of care will be recommended to help prevent future problems and assist in maintaining your good health.

PERSONAL HISTORY

Name: _____ Date of Birth: _____ Age: _____ Gender: * M * F

Address: _____ **Email** _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Driver's License # *(Auto only)*: _____

Employer: _____ Type of Work: _____ Business Phone: _____

Circle One: Married Single Widowed Divorced Separated

Name of Spouse *(If applicable)*: _____ Spouse's Social Security #: _____

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

Names and Ages of Children *(under 21)*: _____

Emergency Contact and Number: _____ Relationship: _____

Who is responsible for your bill? * You * Spouse * Worker's Comp. * Auto Insurance * Medicare * Medicaid

Health Insurance Provider: _____ Policy #: _____

Supplemental Insurance Provider: _____ Policy #: _____

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. 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 upon receipt. However, I clearly understand and agree that all services rendered to 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 to me, they will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as deemed appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any previous medical diagnosis.

_____ _____

Date Patient's Signature

_____ _____

Date Guardian or Spouse's Signature Authorizing Care

HEALTH/HISTORY QUESTIONNAIRE

We want to make sure that you get the best care possible. Below are some questions that will help us determine which program of care is appropriate for you.

1. What is your main complaint? _____
   _____
2. When did this condition originally start? Date _____
3. Is the condition getting worse? _____ Same _____ Better _____
4. How concerned are you about this health problem? Very _____ Not really concerned _____
5. Is this problem ruining or interfering with your life? Yes ____ No ____
6. Do you think that this problem is going to get better? _____ Worse _____
7. You may be required to exercise and modify your diet and lifestyle.
   Is this something you are willing to do for yourself? Yes ____ No ____
8. Are there any time constraints? Yes ____ No ____
9. Who referred you to this office? _____
   We would like to thank them.
10. Drugs you now take: * Anti-depressants * Pain killers/Muscle relaxers * Anti-inflammatories
    * Blood pressure * Cholesterol * Insulin * Hormones _____
    * Other _____

PAST HEALTH HISTORY

PLEASE CHECK AND DESCRIBE:

Major Surgery/Operations: * Appendectomy * Tonsillectomy * Gall Bladder * Hernia

* Broken Bones * Back/Neck Surgery * Other _____

Major Accident or Falls _____

Hospitalization (other than above) _____

Previous Chiropractic Care: * None

* Yes. Doctor's name and approximate date of last visit: _____

Below is a listing 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 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 Disorders
* Lumbago
* Eczema

INTAKE

* Coffee
* Tea
* Alcohol
* Cigarettes
* White Sugar

Continued to the next page

PAST HEALTH HISTORY *Continued*

Check any of the following you have had in the past six months:

MUSCULO-SKELETAL CODE:
* Low Back Pain
* Pain Between Shoulders
* Neck Pain
* Arm Pain
* Joint Pain/Stiffness
* Walking Problems
* Difficulty Chewing/Clicking Jaw
* General Stiffness

GENITO-URINARY CODE:
* Bladder Trouble
* Painful/Excessive Urination
* Discolored Urine

NERVOUS SYSTEM CODE:
* Nervousness
* Numbness
* Paralysis
* Dizziness
* Forgetfulness
* Confusion/Depression
* Fainting
* Convulsions
* Cold/Tingling Extremities
* Stress

C-V-R CODE:
* Chest Pain
* Shortness of 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
* Gas/Bloating After Meals
* Heartburn
* Black/Bloody Stool
* Colitis

FAMILY HISTORY:

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

* Mother * Father
* Brother * Sister
* Spouse * Child

FEMALE/MALE CODE:
* Hormonal Imbalances
* Menstrual Irregularity
* Menstrual Cramps
* Vaginal Pain/Infection
* Breast Pain/Lumps
* Prostate/Sexual Dysfunction
* Other Problems

FEMALES ONLY:

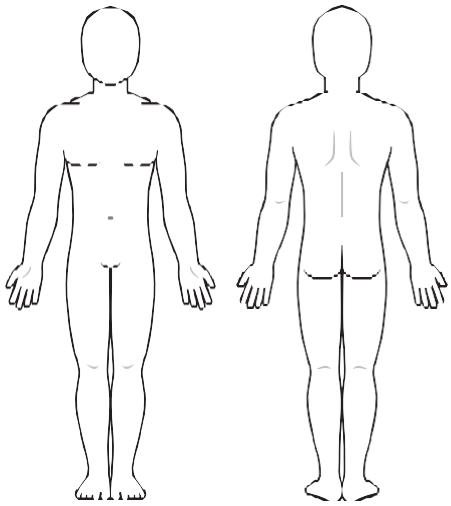
When was your last period?

_____

Are you pregnant?

* Yes * No * Not sure

Please outline on the diagram the area of your discomfort.



Notes:

_____

_____

_____

_____

Thank you for the information above; it will help you and us determine which care program is best for you.