CHIROPRACTIC PLUS

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Date: _____

Name: _____ Date of Birth: _____ Age: _____

Preferred Name to be called _____ Insurance Carrier: _____

Address: _____ Medicare ☐ Yes ☐ No

City/State/Zip: _____ Home Phone: _____

Referred by: _____ Relationship: _____

Email Address: _____

Social Security No. : _____

Responsible Person for Patient: _____

Patient's Employer: _____ Work Phone: _____

Married _____ Single _____ Number of Children _____ Ages _____

List your major problems in order of their importance: _____

_____

Describe the location and nature of your trouble: _____

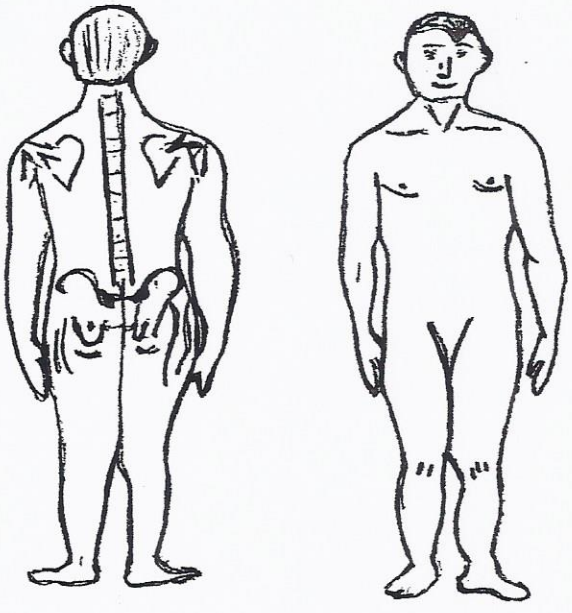
_____

When was the first occurrence of this trouble? _____

How did it occur? _____

Take a moment and think about the activity that brings you joy. How has this impairment negatively impacted this activity? _____

Mark the location of your pain below:



How do the following affect your trouble?

Better	Worse	
_____	_____	Sitting
_____	_____	Standing
_____	_____	Walking
_____	_____	Lying Down
_____	_____	During the night
_____	_____	First thing in morning
_____	_____	End of day
_____	_____	Time of most activity
_____	_____	While resting

What type of medication, vitamins, minerals, etc. are you currently taking? For how long? What for?
(ie: Prilosec/6 months/Acid Reflux) _____

_____

What previous methods have you tried to alleviate your discomfort and did they help at all?

_____

Have you consulted another physician for this problem? ☐ yes ☐ no Name: _____
Did they help? ☐ yes ☐ no

List your major car accidents, falls, and injuries. Give dates _____

_____

_____

List your major diseases. Give dates _____

_____

List any type of surgery or major dental work. Give dates _____

_____

Do you have sufficient energy for your normal activities? _____

Any other symptoms or problems you think the doctor should know? _____

_____

What is your program of regular physical exercise or activity? _____

_____

Have you recently (in the last year) experienced any of the following?

_____ Death of a loved one
_____ Divorce or separation/marital problems
_____ Serious injury or illness of a family member
_____ Marriage
_____ Loss of a job/extreme job stress
_____ Change of a job
_____ Retirement
_____ Pregnancy or birth of a child
_____ Sexual problems
_____ Change of financial status
_____ Revision of personal habits
_____ Change of living conditions
_____ Other extreme stress

Women: Do you experience the following?

_____ Menstrual problems
_____ Excessive flow
_____ Cramping
_____ Pre-menstrual depression
_____ Post-menstrual depression
_____ Painful breasts
_____ Hot flashes
_____ Menopause

Are you pregnant now? _____

Date of last menstrual period _____

How many days do you menstruate? _____

Please check the following that apply:

Does your work or daily activity include:

- ☐ Exposure to fumes
- ☐ Exposure to chemicals
- ☐ Mental stress
- ☐ Physical stress
- ☐ Sitting at a desk
- ☐ Working on hands and knees
- ☐ Standing for long periods
- ☐ Bending
- ☐ Lifting
- ☐ Working overhead

Do you:

- ☐ Grind your teeth? Night ☐ Day ☐
- ☐ Clench your teeth? Night ☐ Day ☐
- ☐ Bruise easily?
- ☐ Have Silver/Mercury Fillings?

Do you sleep:

- ☐ on your stomach?
- ☐ on your back?
- ☐ on your side?

Check the following that apply:

- ☐ Tire easily
- ☐ Exhausted
- ☐ Difficulty staying awake during the day or early evening
- ☐ Nervous
- ☐ Tense
- ☐ Worry easily
- ☐ Been told you are neurotic or trouble was all mental, advised to consult a counselor
- ☐ Crave sweets
- ☐ Lightheaded (black out)
- ☐ Hay fever
- ☐ Asthma
- ☐ Hives
- ☐ Eyes extremely sensitive to light
- ☐ Difficulty getting to sleep
- ☐ Muscle cramps
- ☐ Disposition good

- ☐ Faint or become unconscious
- ☐ Stomach ulcers
- ☐ Other stomach trouble
- ☐ Colitis
- ☐ Gas or burp after eating / acid reflux
- ☐ Indigestion
- ☐ Pain or tight feeling in chest or heart region
- ☐ Heart symptoms
- ☐ Heart beats rapidly and feels shaky when not exercising
- ☐ Vision going bad in either eye
- ☐ Lost weight recently
- ☐ Gained weight recently
- ☐ Dizzy spells (room spins)
- ☐ Stiff neck
- ☐ One side of head hurts worse than the other
- ☐ Know when going to have a headache
- ☐ Headaches apt to occur on certain days of the week or month
- ☐ Know any cause for headaches (i.e. foods, worry, time of month, weather, etc.)

- ☐ Have different kinds of headaches
- ☐ How many days of the month do you have headaches? _____
- ☐ Headaches reoccur at regular intervals

- ☐ Pain makes you get out of bed
- ☐ Had a severe neck injury
- ☐ Unconscious after this injury
- ☐ Instability or unsteadiness associated with posture
- ☐ Mental confusion or forgetfulness
- ☐ Sneezing with temperature change
- ☐ Skin itch

- ☐ Trouble with nails or hair
- ☐ Appetite good
- ☐ Hearing impairment
- ☐ Ear noise - ring
- ☐ Skin dry
- ☐ Cough
- ☐ Gums bleed
- ☐ Sinus trouble
- ☐ Short of breath on mild exertion
- ☐ Rheumatoid arthritis
- ☐ Lower limbs swell
- ☐ Cold feet
- ☐ Feet numb ☐ right ☐ left
- ☐ Feet tingle ☐ right ☐ left
- ☐ Hands numb ☐ right ☐ left
- ☐ Hands tingle ☐ right ☐ left

Smoke how many daily:

Cigarettes _____ Cigar _____ Pipe _____ Chew _____

Drink alcoholic beverages:

How often? _____

What? _____

List food that you would typically eat for:

Breakfast: _____
_____

Lunch: _____
_____

Dinner: _____
_____

How Many:

# of cups of coffee per day? _____ Tea _____
# of glasses of milk per day? _____
# of bottles/cans of juice per day? _____
# of bottles/cans of pop per day? _____
# of glasses of water per day?
city _____ well _____ filtered _____
Bowel movements per day? _____
Hours of sleep per night? _____
wake rested? _____ tired? _____

Snacks: _____

Any food allergies? _____ To what? _____
Any drug allergies? _____ To what? _____
Any environmental allergies? _____ To what? _____

Choose one answer:

I remember important things in my life by:

- ☐ What I see (visual).
- ☐ What I hear (auditory).
- ☐ What I feel (kinesthetic).

Please check the type of care desired:

- ☐ Only temporary relief of symptoms (patch it)
- ☐ Lasting correction / overall health (cause / fix it)

On a scale from (0 – 10) place where you are:
(No pain/problem) 0 _____ 10 – excruciating/discomfort/pain
(None) 0 _____ 10 – motivation to change (I am ready now).

Patient Payment Policy

1. Patients are expected to take care of their fees as services are rendered.

2. Patients, who carry health insurance other than Blue Cross/Blue Shield, should remember that services are rendered and charged to the patient and not to the insurance company. We do participate with traditional Blue Cross. Patients are expected to pay their co-pay and deductible at each visit.

3. Our “Super Bill” has sufficient information to be directly attached to the claim form provided by your insurance carrier. If you have questions or problems, we will of course assist you.

4. We do not participate with Medicare. We are, however, required to bill Medicare directly for your reimbursement. While we will take care of the billings, all payments, denials, etc. will be sent directly to you.

5. For Non-insurance patients, we offer a multi-visit package discount. Ask the front desk person for the program that might help meet your needs.

I have read the above and agree to be financially responsible for all changes at this office including my insurance deductibles, co-payment and any services rejected by my insurance company. (If you are unable to meet the above financial obligation, special arrangements must be discussed with the Office Manager.

_____ _____
Patient’s Signature Date

Identifying Beliefs to Change

My Top Three goals in life are:

1. _____
2. _____
3. _____

To Achieve these life goals, I need to BELIEVE:

1. _____
2. _____
3. _____

Physical/Health Challenges (e.g.: back/neck/arm pain, headaches, weight, energy, sleep, disease)

_____
_____

Emotional Challenges (e.g.:grief, stress, fears, phobias, anger, assertiveness, depression, addictions)

_____
_____

Mental Challenges (e.g.: memory, focus, learning challenges)

_____
_____

What is missing from your life? What would make your life more fulfilling?

_____
_____

What accomplishments must, in your opinion, occur during your lifetime so that you will consider your life to have been satisfying and well lived – a life of few or no regrets?

_____
_____
_____

Do you laugh? How often?

_____
_____

YOUR THOUGHTS ARE CRITICAL TO OUR SUCCESS IN HELPING YOU

Your nervous system is the master system and controller of your body. Health and wellness are therefore mediated through your nervous system. In our office we have a unique and modern approach to supporting and expanding your health by improving how your nervous system performs. The Core Score is the results of the series of tests with the Insight technology that your doctor had ordered on you, scales from 0-100. The higher the score, the better your Core Score. A graph representing this is below.

Lifestyle stress adversely affects your nervous system and general health. Many times, when people think they have a "back problem", what they really have is a "health problem" that is a result of the way they are living.

Please answer the following questions so we may better understand how to help you:

1. On a scale of 1 to 10 (10 being the most important) how important is your health to you?

   _____

On the scale below:

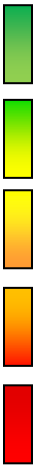
2. Place an "X" to score where you think you are today
3. Please circle where you would like to be (your goal)

90-100 (EXCELLENT)

80-89 (GOOD)

80-79- (TRANSITION)

60-69 (CHALLENGED)



4. How long do you think it might take to get to where you circled?

_____

5. What things might you need to change to help reach your goal?

A. _____
B. _____
C. _____
D. _____

6. If we could make recommendations that would not only address your main concerns, but could also help with improving your overall health, would you like to hear them? Yes____ or No____