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TO THE NEW PATIENT

OUTLINE OF PROCEDURES FOR NEW PATIENTS

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

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

3. STEP THREE:
Chiropractic examination and Orthopaedic and Neurological examinations as related to chiropractic to determine if chiropractic care will help you.

4. STEP FOUR:
The doctor will advise you as to the need of additional procedures such as 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:
Chiropractic adjustments will begin and continue as scheduled until maximum correction has been obtained.

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

To save time and to allow us to serve you better, please complete all questions on the next three pages.

ENTRANCE RECORD: Please write or print very carefully, we want all the facts about your health before we accept your case. Your report is confidential and is treated as such by our staff.

Name in full: _____ Address: _____ Apt. No: _____

City: _____ Postal Code: _____ Phone No: Res. _____ Bus. _____

Occupation: _____ Cell: _____ Initial _____

Date of Birth: Day _____ Mo. _____ Year _____ Height _____ Weight: _____

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Spouse's First Name: _____ Number of Children: _____ Ages: _____

Previous Chiropractic Care: By Whom, where, when, how long: _____

EMAIL: _____ Referred By: _____

Please check the appropriate box for any of the following symptoms which you *now have or had previously*. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE AND THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Veneral Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Is this an Industrial Accident Case? ☐ Yes ☐ No Address _____ Policy # _____

PLEASE PRINT

What is your major complaint? _____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

List surgical operations and years _____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ Others _____

Dental visits: ☐ Every 6 months ☐ Yearly ☐ Toothache or "emergency" only ☐ Complete dentures

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____
DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6 to 18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

— PAYMENT IS EXPECTED AT TIME OF VISIT —

Name of Person Responsible for Payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account on 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 my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature X _____

(IF PATIENT IS A MINOR, NAME OF PARENT, GUARDIAN, ETC.)

Why Chiropractic? People go to 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 Care **(Preventive Care)**. These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his 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 [ ] Preventive Care [ ] Check here if you want the doctor to select the type of care appropriate for your condition.

_____ Date

_____ Patient's Signature

_____ Parent or Guardian's Signature Authorizing Care

_____ Date

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.

DO NOT WRITE BELOW THIS LINE

PATIENT ACCEPTED: ( ) YES ( ) NO ( ) REFERRED DATE _____

DIAGNOSIS _____ Dr._____