WELCOME TO OUR PRACTICE

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE REQUIRE THE FOLLOWING INFORMATION. PLEASE PRINT LEGIBLY. IN ACCORDANCE WITH FEDERAL & STATE HIPPA REQUIREMENTS ALL INFORMATION PROVIDED IS CONFIDENTIAL.

We have a holistic view of health and healing that considers the whole person and not just the area hurting. We have many types of treatments to help you with your health concerns.

DATE: _____ PATIENT NAME: _____ PATIENT #: _____

SS#/SIN: _____ □ MALE □ FEMALE DATE OF BIRTH: _____ Age____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

CHECK APPROPRIATE BOX: □ MINOR □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

PATIENT OR PARENT/GUARDIAN'S EMPLOYER: _____ WORK PHONE: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE OR PARENT/NAME: _____ WORK PHONE: _____ Cell Phone_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

How did you find out about our office? Were you referred by one of our patients?_____

_____

If we need to contact you about your appointment, would you prefer: card, phone, email? Number to use and time of day_____

To receive our patient newsletter by email, please indicate your current email address. We will not give your email address to anyone else. It is only used for correspondence.

EMAIL ADDRESS:_____

Chiropractic Care And Insurance

Health insurance policies are structured around Medical care and not Chiropractic care. Some of the services we provide are **NOT** covered by your health care plan.

Examples of Services Not Covered

Reflex exam Nutritional Supplements Allergy Exam Foot Bath

Homeopathics Frequency Specific Micro-current Re-connective Healing

PRIMARY INSURANCE INFORMATION

We are network providers for Blue Cross and accept major credit cards, personal checks, and cash.

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SS#/SIN: _____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ PATIENT ID: _____ GROUP#: _____

INSURANCE COMPANY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY EFFECTIVE DATE: _____ DEDUCTIBLE AMOUNT: _____ AMT MET TO DATE? _____

We will photocopy your insurance card and drivers license

If your insurance is not one listed above, we will give you a super bill or HCFA form to submit to your insurance company.

I understand that some of the services that I may receive are not covered by insurance plans. I will be responsible for submitting my claim to my insurance company.

Signature:_____ Date_____

YOUR EXPECTATIONS OF US

PATIENTS SEEK CARE 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 TO AVOID FUTURE RELAPSES (CORRECTIVE CARE). STILL OTHERS WANT WHATEVER IS "MALFUNCTIONING" IN THEIR BODIES BROUGHT TO THE HIGHEST STATE OF HEALTH POSSIBLE IN ORDER TO OPTIMIZE THEIR PHYSICAL AND EMOTIONAL WELLBEING (COMPREHENSIVE CARE). OUR OFFICE OFFERS SOME OF THE LATEST ADVANCED PROCEDURES FOR OPTIMIZING YOUR NERVOUS SYSTEM FUNCTION.

ADDITIONALLY, OUR OFFICE STRESSES THAT IT IS YOUR HEALTH AND "YOUR CHOICE" TO DECIDE WHICH TYPE OF CARE YOU WISH TO RECEIVE. OUR DOCTORS WILL WEIGH YOUR NEEDS AND DESIRES WHEN RECOMMENDING YOUR TREATMENT PROGRAM. PLEASE CHECK THE TYPE OF CARE YOU WISH TO RECEIVE.

☐ RELIEF CARE ☐ CORRECTIVE CARE ☐ COMPREHENSIVE CARE ☐ WOULD LIKE TO DISCUSS OPTIONS WITH DOCTOR

HISTORY OF PRESENT ILLNESS/CONCERN DATE_____

AS A NEW PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW TO THE BEST OF YOUR ABILITY. SHOULD YOU HAVE MULTIPLE AREAS OF CONCERN (NECK, BACK, HEADACHES, TREMORS, VERTIGO...), PLEASE PRINT AND COMPLETE THIS SHEET FOR EACH AREA/CONCERN.

DESCRIBE THE PROBLEMS/SYMPTOMS THAT YOU ARE EXPERIENCING. _____

_____

WHEN DID THIS PROBLEM BEGIN? _____

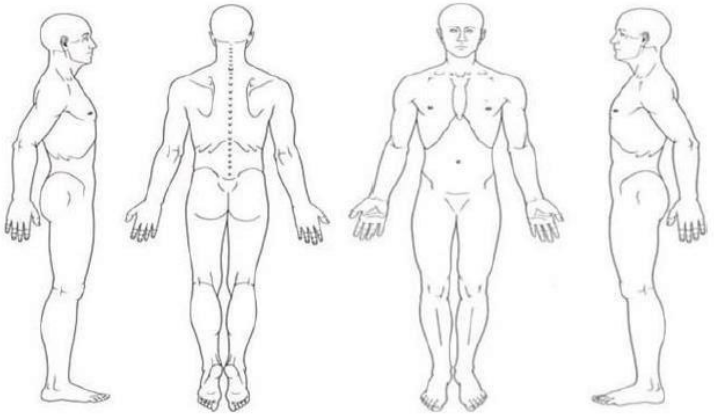
IF THIS A REOCCURRENCE OF AN EXISTING CONDITION, WHEN DID THE PROBLEM ORIGINALLY BEGIN? _____

HOW DID YOUR SYMPTOMS START (IE...TRAUMA, UNKNOWN): _____

HOW OFTEN ARE YOU EXPERIENCING SYMPTOMS? (CIRCLE ONE)

A. CONSTANTLY (76-100% OF THE DAY)
B. FREQUENTLY (51-75% OF THE DAY)
C. OCCASIONALLY (26-50% OF THE DAY)
D. INTERMITTENTLY (0-25% OF THE DAY)

NATURE OF YOUR SYMPTOMS & INDICATE ON DIAGRAM ⇨



A. SHARP
B. SHOOTING
C. DULL ACHE
D. NUMB
E. BURNING
F. TINGLING

INDICATE THE AVERAGE INTENSITY OF YOUR SYMPTOMS: NONE 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

HOW ARE YOUR SYMPTOMS CHANGING?

A. GETTING BETTER
B. NOT CHANGING
C. GETTING WORSE

WHAT TESTING HAVE YOU HAD FOR THIS CONDITION?

□ MRI □ X-RAYS
□ CT SCAN □ LABORATORY WORK
□ EKG □ OTHER: _____

WHAT MAKES YOUR CONDITION BETTER? _____

WHAT MAKES IT WORSE? _____

DOES IT AFFECT YOUR ABILITY TO SLEEP OR WAKE YOU AT NIGHT? YES NO

HOW MUCH HAS THIS CONDITION INTERFERED WITH YOUR ACTIVITIES OF DAILY LIVING (INCLUDING WORK, SOCIAL, SELF/FAMILY CARE)

A. NOT AT ALL B. A LITTLE BIT C. MODERATELY D. QUITE A BIT E. EXTREMELY

PLEASE LIST ANY OTHER PROVIDERS (MEDICAL DOCTOR, PHYSICAL THERAPIST, CHIROPRACTOR, ETC...) THAT YOU HAVE CONSULTED FOR THIS CONDITION. LIST THE APPROXIMATE DATE OF THE LAST VISIT, DIAGNOSIS AND THEIR CONTACT INFORMATION. (USE BACK IF NECESSARY)

1. _____
2. _____

PLEASE INCLUDE ANY OTHER RELEVANT HISTORY/INFORMATION REGARDING THIS COMPLAINT. _____

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

MEASLES	NO	YES	ARTHRITIS	NO	YES	NECK PAIN	NO	YES	HEPATITIS (A, B, C, D)	NO	YES
MUMPS	NO	YES	ANEMIA	NO	YES	BACK PAIN	NO	YES	ULCER	NO	YES
CHICKENPOX	NO	YES	VENEREAL DISEASE	NO	YES	HIGH BLOOD PRESSURE	NO	YES	MITRAL VALVE PROLAPSE	NO	YES
WHOOPING COUGH	NO	YES	EPILEPSY	NO	YES	LOW BLOOD PRESSURE	NO	YES	AUTOIMMUNE DISEASE	NO	YES
SCARLET FEVER	NO	YES	HERNIA	NO	YES	MULTIPLE SCLEROSIS	NO	YES	THYROID DISEASE	NO	YES
DIPHTHERIA	NO	YES	TUBERCULOSIS	NO	YES	HIVES/ECZEMA	NO	YES	MIGRAINE HEADACHES	NO	YES
SMALL POX	NO	YES	DIABETES	NO	YES	AIDS/HIV+	NO	YES	STROKE	NO	YES
PNEUMONIA	NO	YES	CANCER	NO	YES	FIBROMYALGIA	NO	YES	TIA	NO	YES
RHEUMATIC FEVER	NO	YES	POLIO	NO	YES	BRONCHITIS	NO	YES	ASTHMA	NO	YES
HEART DISEASE	NO	YES	GLAUCOMA	NO	YES	HEMORRHOIDS	NO	YES	DIVERTICULITIS	NO	YES
PERSISTENT COUGH > 3 WKS	NO	YES	IRREGULAR HEART BEAT	NO	YES	BLOOD / PLASMA TRANSFUSION	NO	YES	KIDNEY DISEASE	NO	YES
BLADDER INFECTION	NO	YES	RESTLESS LEG SYNDROME	NO	YES	INFECTIOUS MONONUCLEOSIS	NO	YES	BLEEDING TENDENCY	NO	YES

PREVIOUS HOSPITALIZATIONS/SURGERIES/ AUTO ACCIDENTS/ PERSONAL INJURIES

DESCRIPTION	DATE	HOSPITAL, CITY, STATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (*INCLUDE NON-PRESCRIPTION*) – USE BACK SIDE IF NECESSARY

DRUG NAME	DOSE	CONDITION/REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SOCIAL HISTORY

MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ SEPARATED	☐ DIVORCED	☐ WIDOWED
USE OF ALCOHOL	☐ NEVER	☐ RARELY	☐ MODERATELY	☐ DAILY	
USE OF TOBACCO	☐ NEVER	☐ PREVIOUSLY _____ YRS, BUT QUIT: _____		☐ CURRENT PACK/DAY/YR:_____	
USE OF DRUGS	☐ NEVER	☐ TYPE/FREQUENCY/YRS: _____			
USE OF CAFFEINE	☐ NEVER	☐ RARELY	MODERATELY	☐ DAILY	
EXPOSURE TO:	☐ FUMES	☐ DUST	☐ SOLVENTS	☐ AIRBORNE PARTICLES	☐ NOISE

FAMILY HISTORY

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
SIBLINGS	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____

Excercise: None_____ Moderate_____ times/week Heavy_____times/week

Types of Exercise:_____

REVIEW OF SYSTEMS: *PLEASE INDICATE ANY PERSONAL HISTORY BELOW*

CONSTITUTIONAL

GENERAL GOOD HEALTH	NO	YES
RECENT WEIGHT CHANGE	NO	YES
FEVER	NO	YES
FATIGUE	NO	YES
HEADACHES	NO	YES

EYES

EYE DISEASE OR INJURY	NO	YES
WEAR GLASSES/CONTACTS	NO	YES
BLURRED/DOUBLE VISION	NO	YES
VISUALIZE SPOTS OR COLORS	NO	YES

EARS/NOSE/THROAT

HEARING LOSS/RINGING	NO	YES
EARACHES OR DRAINAGE	NO	YES
MUCUS MEMBRANE DRYNESS	NO	YES
NOSE BLEEDS	NO	YES
MOUTH SORES	NO	YES
BLEEDING GUMS	NO	YES
BAD BREATH/BAD TASTE	NO	YES
SORE THROAT/VOICE CHANGE	NO	YES
SWOLLEN GLANDS	NO	YES

CARDIOVASCULAR

HEART TROUBLE	NO	YES
CHEST PAIN / ANGINA PECTORIS	NO	YES
PALPITATIONS/ARRHYTHMIAS	NO	YES
SHORTNESS OF BREATH W/ EX.	NO	YES
SWOLLEN FEET, ANKLES, HANDS	NO	YES

RESPIRATORY

CHRONIC OR FREQUENT COUGH	NO	YES
SPITTING UP BLOOD	NO	YES
SHORTNESS OF BREATH	NO	YES
WHEEZING	NO	YES

GASTROINTESTINAL

LOSS OF APPETITE	NO	YES
CHANGE IN BOWEL MOVEMENTS	NO	YES
NAUSEA OR VOMITING	NO	YES
DIARRHEA OR CONSTIPATION	NO	YES
PAINFUL BOWEL MOVEMENTS	NO	YES
BLOOD IN STOOL	NO	YES
ABDOMINAL PAIN	NO	YES
RECTAL BLEEDING	NO	YES
STOOL THAT FLOATS	NO	YES
HEMORRHOIDS		

GENITOURINARY

FREQUENT URINATION	NO	YES
BURNING/PAINFUL URINATION	NO	YES
BLOOD IN URINE	NO	YES
CHANGE IN FORCE OF STREAM	NO	YES
INCONTINENCE OR DRIBBLING	NO	YES
KIDNEY STONES	NO	YES
SEXUAL DIFFICULTY	NO	YES
MALE – TESTICLE PAIN	NO	YES
FEMALE- PAINFUL PERIODS	NO	YES
FEMALE- IRREGULAR PERIODS	NO	YES
FEMALE-VAGINAL DRYNESS	NO	YES
FEMALE - # OF PREGNANCIES:	_____	
FEMALE - # OF MISCARRIAGES	_____	
FEMALE – DATE OF LAST PAP	_____	

MUSCULOSKELTAL

JOINT PAIN	NO	YES
JOINT STIFFNESS/SWELLING	NO	YES
MUSCLE/JOINT WEAKNESS	NO	YES
MUSCLE PAIN OR CRAMPS	NO	YES
BACK PAIN	NO	YES
COLD EXTREMITIES	NO	YES
DIFFICULTY WALKING	NO	YES

INTEGUMENTARY (SKIN)

RASH OR ITCHING	NO	YES
CHANGE IN SKIN COLOR	NO	YES
CHANGE IN HAIR OR NAILS	NO	YES
VARICOSE VEINS	NO	YES
BREAST PAIN	NO	YES
BREAST LUMP	NO	YES
BREAST DISCHARGE	NO	YES

NEUROLOGICAL

FREQUENT HEADACHES	NO	YES
LIGHTHEADED OR DIZZY	NO	YES
CONVULSIONS OR SEIZURES	NO	YES
NUMBNESS OR TINGLING	NO	YES
TREMORS OR TICS	NO	YES
PARALYSIS	NO	YES
HEAD INJURY	NO	YES
LOSS OF CONSCIOUSNESS	NO	YES
FACIAL DROOPING/WEAKNESS	NO	YES
SPONTANEOUS MOVEMENT	NO	YES
MOVEMENT DISORDER	NO	YES

PSYCHIATRIC

MEMORY LOSS/CONFUSION	NO	YES
NERVOUS OR ANXIOUS	NO	YES
DEPRESSION	NO	YES
INSOMNIA	NO	YES
LOSS OF MOTIVATION	NO	YES

ENDOCRINE

GLANDULAR PROBLEM	NO	YES
HORMONE PROBLEM	NO	YES
HEAT/COLD INTOLERANCE	NO	YES
SKIN BECOMING DRYER	NO	YES
CHANGE IN HAT/GLOVE SIZE	NO	YES
UNUSUAL HAIR GROWTH	NO	YES

HEMATOLOGIC/LYMPHATIC

SLOW TO HEAL AFTER CUTS	NO	YES
BLEEDING OR BRUISING TENDENCY	NO	YES
ANEMIA	NO	YES
PHLEBITIS	NO	YES
PAST TRANSFUSION	NO	YES
ENLARGED GLANDS	NO	YES
ANEMIA	NO	YES

ALLERGIC/IMMUNOLOGIC

HISTORY OF ADVERSE REACTION TO:	NO	YES
PENICILLIN OR OTHER ANTIBIOTICS	NO	YES
MORPHINE, DEMEROL, NARCOTICS	NO	YES
NOVOCAIN OR OTHER ANESTHETICS	NO	YES
ASPIRIN OR OTHER PAIN REMEDIES	NO	YES
TETANUS ANTITOXIN OR SERUMS	NO	YES
IODINE, MERTHIOLATE, ANTISEPTICS	NO	YES

OTHER DRUGS AND MEDICATIONS: _____

_____

_____

KNOWN FOOD ALLERGIES: _____

_____

_____

ENVIRONMENTAL ALLERGIES: _____

_____

_____

AUTHORIZATION & RELEASE: To the best of my knowledge, the questions on these forms have been answered accurately and completely. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare provider and staff to perform the necessary services I may need.

_____ _____

Signature of Patient (parent/guardian) Date

DOCTOR REMARKS: