

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. _____

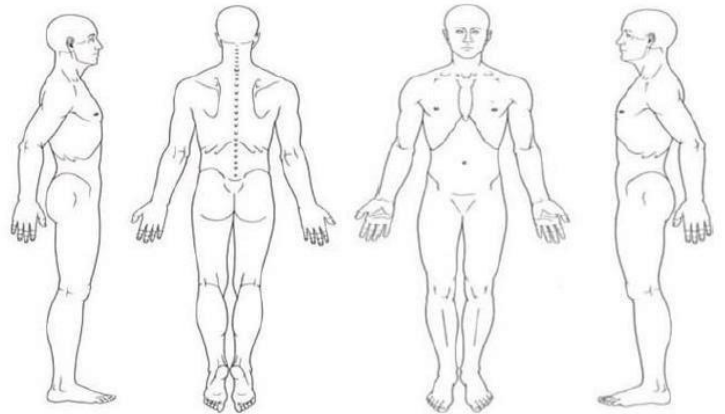
WHEN DID THIS PROBLEM BEGIN? _____


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	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED
USE OF ALCOHOL	<input type="checkbox"/> NEVER	<input type="checkbox"/> RARELY	<input type="checkbox"/> MODERATELY	<input type="checkbox"/> DAILY	
USE OF TOBACCO	<input type="checkbox"/> NEVER	<input type="checkbox"/> PREVIOUSLY _____ YRS, BUT QUIT: _____	<input type="checkbox"/> CURRENT PACK/DAY/YR: _____		
USE OF DRUGS	<input type="checkbox"/> NEVER	<input type="checkbox"/> TYPE/FREQUENCY/YRS: _____			
USE OF CAFFEINE	<input type="checkbox"/> NEVER	<input type="checkbox"/> RARELY	<input type="checkbox"/> MODERATELY	<input type="checkbox"/> DAILY	
EXPOSURE TO:	<input type="checkbox"/> FUMES	<input type="checkbox"/> DUST	<input type="checkbox"/> SOLVENTS	<input type="checkbox"/> AIRBORNE PARTICLES	<input type="checkbox"/> NOISE

FAMILY HISTORY

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

Exercise: 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 NO YES

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: