

NEW PATIENT IN TAKE



STEP ONE:

Welcome to our Practice

STEP TWO:

All New Arrivals fill out this personal health history questionnaire.

STEP THREE:

A tour of our Facility

STEP FOUR:

A one-on-one Education on how to improve YOUR health and well-being.

STEP FIVE:

A one-on-one conversation with our Doctor of Chiropractic.

STEP SIX:

A special Media Presentation about the Pro-Solution.

STEP SEVEN:

A report will be given to you about how your health can improve.

Confidential Patient Health Record

DATE: _____

PERSONAL HISTORY

Name: _____ Address: _____

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

Home Phone: _____ Birth Date: _____ Age: _____ Sex: Male or Female

Social Security #: _____

Social Insurance #: _____ E-Mail Address: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Business Phone: _____

Type of Work: _____ Name and Ages of Children: _____

Referred To This Office By: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is Responsible for Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid

Personal Health Insurance (Name) _____ Health Card # _____

Insured Person's Name _____ Date of Birth: _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other Doctors Seen for this Conditions: YES NO Who? _____

Type of Treatment: _____ Results: _____

When did this Conditions Begin? _____ Has this Condition Occurred Before? YES NO

Is Conditions: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made a Report of Your Accident to Your Employer: YES NO

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine

Insulin Other: _____

Do You Wear A Shoe Lif? YES NO

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

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

Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which 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 care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|-----------------|---------------|------------------|-------------|
| Pneumonia | Mumps | Influenza | INTAKE |
| Rheumatic Fever | Small Pox | Pleurisy | Coffee |
| Polio | Chicken Pox | Arthritis | Tea |
| Tuberculosis | Diabetes | Epilepsy | Alcohol |
| Whooping Cough | Cancer | Mental Disorders | Cigarettes |
| Anemia | Heart Disease | Lumbago | White Sugar |
| Measles | Thyroid | Eczema | |

Have you been tested HIV positive? YES No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | |
|--------------------------------|--------------------------|
| Low Back Pain | Gas/Bloating After Meals |
| Pain Between Shoulders | Heartburn |
| Neck Pain | Black/Bloody Stool |
| Arm Pain | Colitis |
| Joint Pain/Stiffness | |
| Walking Problems | |
| Difficult Chewing/Clicking Jaw | |
| General Stiffness | |

GENTO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short 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

MALE/FEMALE CODE

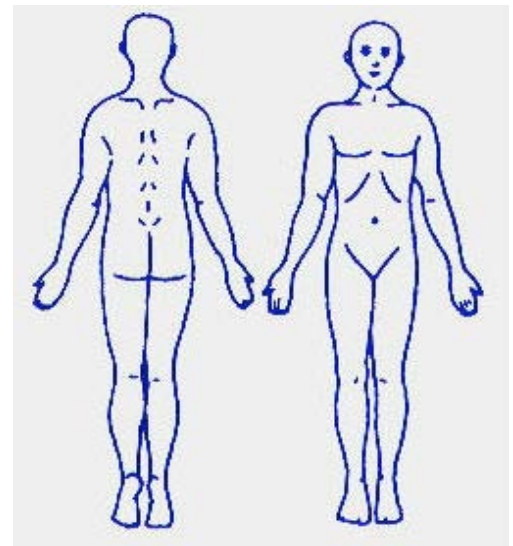
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

YES NO Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

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

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: YES NO Referred

Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come 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). Your Doctor will weigh you needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

**Relief
Care**

**Corrective
Care**

**Check here if you want the Doctor to select
the type of care appropriate for your condition**

Date

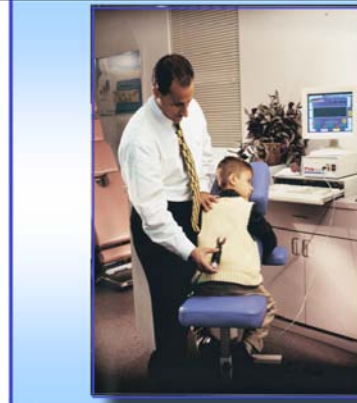
Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You !



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in Length of time, but is more lasting

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 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 me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date: _____

Consent to treat a Minor _____

Date: _____

**Guardian or Spouse's
Signature of Authorizing Care:** _____

Date: _____