To the New Patient

OUTLINE OF PROCEDURES FOR CARE

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

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the case.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will be given a Report of Finding at which time the cause of your problem will be discussed. It includes a through explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Confidential Patient Health Record

Date	I.D. NO.

PERSONAL HISTORY

Name:______________________ Address:______________________

City:______________________ State:__________Zip Code:__________

Home Phone:______________________ Birth Date: ________ Age: ______ Sex: M F

Cell Phone:______________________ E-mail Address:______________________

Social Security#:______________________ Driver's License Number: ______________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer:______________________ Type of Work:______________________

Business Phone:______________________

Name of Spouse:______________________ Spouse's SS#:______________________

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 ☐ Worker's Comp. ☐ Auto Insurance ☐ Medicare ☐ Attorney

☐ Personal Health Insurance (Name):______________________

☐ Health Card #:______________________

Insured Person's Name:______________________ Date of Birth:______________________

CURRENT HEALTH CONDITION

Unwanted Health Condition______________________

Other Doctors Seen For This Condition: ☐ Yes Who?______________ ☐ No

Type of treatment:______________________ Results:______________________

When Did This Condition Begin?______________________ Has This Condition Occurred Before? Yes No

Is this condition: ☐ Job related ☐ Auto accident ☐ Home injury ☐ Fall ☐ Other:__________

Date of the Accident:______________________ Time of accident:______________________

Have You Made A Report of Your Accident To Your Employer? ☐ Yes ☐ No

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

☐ Insulin ☐ Other______________________

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition 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 accident or falls:______________________

Hospitalization (Other Than Above)______________________

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 DISEASE YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Lumbago
- ☐ Eczema
- ☐ Mental Disorder

INTAKE

- ☐ coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White sugar

Have you been tested for HIV positive? Yes No

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

MUSCULO-SKELETAL CODE

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

Nervous System Code

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

General Code

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R Code

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

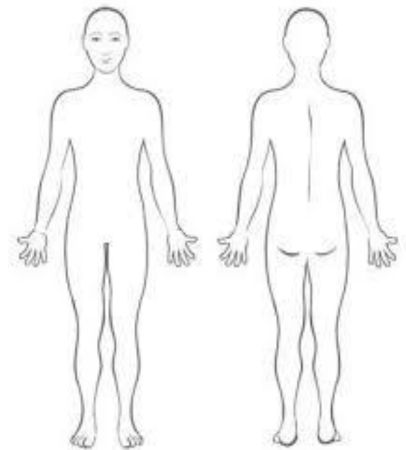
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY:

When was your period? __________

Are you pregnant?

Yes No Not Sure



Please outline on the diagram the area of your discomfort.

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
- ☐ __________________________
- ☐ __________________________
- ☐ __________________________

FAMILY HISTORY

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

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

PLEASE DO NOT WRITE BELOW THIS LINE

Analysis:____ Diagnosis____

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 your needs and desires when recommending your treatment program.

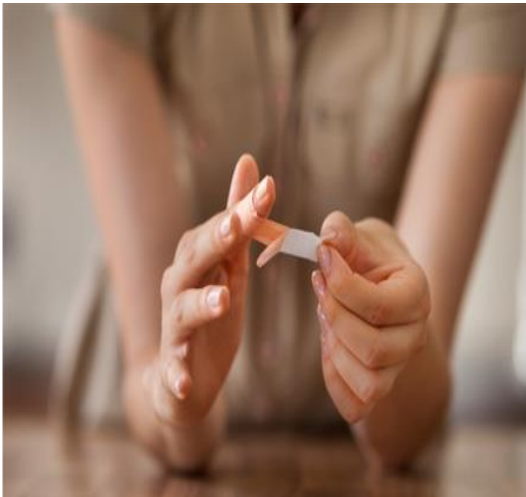
Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care
- ☐ Corrective care
- ☐ Check here if you want your Doctor to select the type of care appropriate for your condition

___________________________ Date

____ Patient 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 on 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 property of this office, being on the 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*____________________