



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 cause.

**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 Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

**STEP SIX:**

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

**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.

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Social Insurance # \_\_\_\_\_ Circle One: Married  Single  Widowed  Divorced  Separated  
 Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Spouse's Social Insurance # \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_ Name and Ages of Children \_\_\_\_\_  
 Referred To This Office By: \_\_\_\_\_ Email Address \_\_\_\_\_  
 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 Condition: Yes  No  Who? \_\_\_\_\_  
 Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_  
 When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before? Yes  No   
 Is Condition: 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 Lift? 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 Accident 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:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

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
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**GENITO-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**

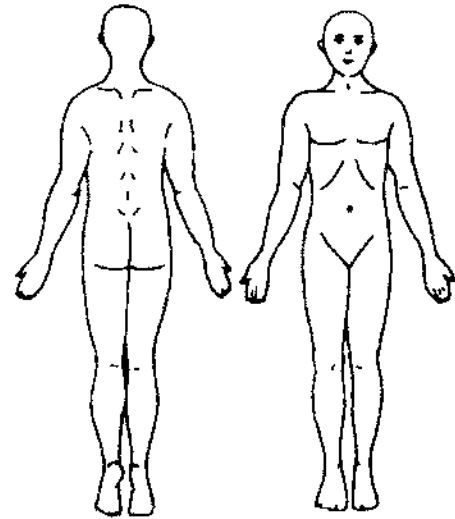
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- \_\_\_\_\_
- \_\_\_\_\_

**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

