

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the Chiropractic Assistant. PLEASE PRINT

Name _____ Home Phone _____ Work Phone _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D No. of Children _____
Email Address _____

Please circle one payment type: Cash Check Master Card/Visa American Express
Your Employer _____ Occupation _____ Years on Job _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____
Do you have Medicare? Yes _____ No _____ Medicaid? Yes _____ No _____
Name of Spouse or Parent _____ Birth Date _____
Spouse employed by _____ Occupation _____ Years on Job _____
Employer Address _____ City _____ State _____ Zip _____
Office Phone _____ Does your spouse have health insurance at work? Yes _____ No _____

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(please list any conditions you are being treated for or experiencing.)

Referred to our office by: _____

How Payment will be made: _____ Type of Insurance _____
_____ Cash _____ Workman's Comp _____ Health Insurance
_____ Check _____ Credit Card _____ Automobile Ins. Policy

Is your condition due to an accident? Yes _____ No _____ Date of Accident _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an Auto Accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patients Signature _____ Date _____
Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance Cases: on all insurance assignments the deductible should be met in the beginning unless prior arrangements are made.

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU

Name _____ Date _____

Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive Hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged Glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gurn trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore Throat
- Tonsillitis

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid Heart Beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin Eruptions (rash)
- Varicose veins

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal Discharge
- Y ___ N Are you pregnant?

CHECK THE FOLLOWING CONDITION YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping Cough |

PLEASE PRINT

What is your major complaint? _____

List surgical operation and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers
 "Pep" pills Tranquilizers Birth Control Pills

Others: _____

Age of Mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year Past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	—	—	_____
Used a cane, crutch, or other support?	—	—	_____
Been treated for a spine or nerve disorder?	—	—	_____
Had a fractured bone?	—	—	_____
Been hospitalized for anything other than Surgery?	—	—	_____

DO YOU:	Yes	No	DESCRIBE BRIEFLY
Now take vitamins or minerals?	—	—	_____
Think you may need vitamins or minerals?	—	—	_____
Have an allergy to any drug?	—	—	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Examination	—	—	—	—
Physical examination	—	—	—	—
Blood Test	—	—	—	—
Chest X-Ray	—	—	—	—
Spinal X-ray	—	—	—	—
Dental X-ray	—	—	—	—
Urine Test	—	—	—	—

HABITS	Heavy	Moderate	Light	None
Alcohol	—	—	—	—
Coffee	—	—	—	—
Tobacco	—	—	—	—
Drugs	—	—	—	—
Exercise	—	—	—	—
Sleep	—	—	—	—
Appetite	—	—	—	—

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):
 NAME _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient: _____

Please review the below-listed diseases and conditions and indicate these that are current health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climates.

CONDITION	FATHER Age ()	MOTHER Age ()	SPOUSE Age ()	BROTHER(s) Age ()	SISTER(s) Age ()	CHILDREN Age () Age ()
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

ENTRANCE RECORD

When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking and working toward the same goals.

Chiropractic has one goal. It is therefore important that you understand the goal and our means to attain it. In this way there will be NO confusion, misunderstanding or disappointment.

1. YOU must realize that Chiropractic is NOT a substitute for medical treatment of any kind, in any way, for any reason. Also, NO statement of the Chiropractor is intended as a medical diagnosis and should not be confused as such. Patients usually want to get rid of whatever ailments. Symptoms or conditions are bothering them. This however, is NOT the goal of the chiropractor. Chiropractic is not intended to be treatment of the symptoms of a medical condition or to treat the cause or causes of a medical condition.
2. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. Subluxations come from many causes and prevent various organs, glands, and tissues from functioning properly.
3. By means of a chiropractic adjustment, subluxations are corrected (reduced) and the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability to the body to work a maximum efficiency .
4. With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of disease.

The information we receive from you is important. We ask only that which is necessary to our chiropractic health Maintenance Center. For this reason, please fill out this form completely and to the best of your ability. If you have any questions or there is any information you feel we should know, please mention it to the doctor.

I, _____, have read the above, understand it fully, and undertake chiropractic care on this basis.

Date: _____