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

Today's Date_____
Name_____ Home Phone_____ Work Phone_____
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:
_____ Cash
_____ Check

Type of Insurance
_____ Workman's Comp
_____ Credit Card

_____ Health Insurance
_____ 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, ant 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-INTESTIONAL
__ 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:

__ Alcoholism	__ Cold sores	__ Goiter	__Miscarriage	__Scarlet fever
__ Anemia	__ Diabetes	__ Gout	__ Multiple sclerosis	__ Stroke
__ Appendicitis	__ Diphtheria	__ Heart Disease	__ Mumps	__ Tuberculosis
__ Arteriosclerosis	__ Eczema	__ Influenza	__ Pleurisy	__ Typhoid fever
__ Arthritis	__ Emphysema	__ Lumbago	__ Pneumonia	__ Ulcers
__ Cancer	__ Epilepsy	__ Malaria	__ Polio	__Venereal disease
__ Chorea	__ Fever Blisters	__ Measles	__ Rheumatic fever	__ 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:			
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 goad 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:_____