

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 or case manager 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

First Name _____ Middle _____ Last Name _____

Street Address/P.O. Box # _____ City _____ State _____ Zip Code _____

Home Phone# _____ Work Phone# _____ Extension _____

Cell Phone # _____ Email Address _____

Date of Birth _____ Gender: Male Female Social Security Number _____
(Please Circle One)

Marital Status: **Single Married Div. Wid.** (Please Circle One)

Patient's Employer's Name _____

Employer's Street Address _____ City _____ State _____ Zip Code _____

Health Concern or Area of Complaint _____ Date of Onset _____

If you have a Spouse/Significant Other, please provide the following information:

First Name _____ Middle _____ Last Name _____

Date of Birth _____

Their Employer's Name _____

Their Employer's Street Address _____ City _____ State _____ Zip Code _____

Emergency Contact _____ Emergency Phone# _____ Relationship _____

Primary Insurance Company

Secondary Insurance Information

| | |
|---|---|
| Name of Health Insurance Company _____ | Name of Health Insurance Company _____ |
| Name of Policyholder / Relationship _____ | Name of Policyholder / Relationship _____ |
| Name of Insured's Employer _____ | Name of Insured's Employer _____ |
| Policy # _____ Group # _____ | Policy # _____ Group # _____ |

SOCIAL HISTORY

| | | | | | |
|--|--|---|---|---|--|
| Marital Status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | How often do you eat a well-balanced diet? <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> usually <input type="checkbox"/> always | How often do you exercise? <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> regularly | Have you traveled internationally? <input type="checkbox"/> never <input type="checkbox"/> recently <input type="checkbox"/> occasionally <input type="checkbox"/> in the past | Recreational Drug Use? (optional) <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often <input type="checkbox"/> in the past | Hours of Sleep per night? <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 5 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 7 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> 9 hours <input type="checkbox"/> 10 or more |
| Years of Education? (optional) <input type="checkbox"/> Less than 10 <input type="checkbox"/> 14 years <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 11 years <input type="checkbox"/> 16 years <input type="checkbox"/> 12 years <input type="checkbox"/> more than 16 <input type="checkbox"/> 13 years | | # of Children? _____ | | What is your average yearly income? (optional) _____ | |

| | |
|---|--|
| How often do you drink beverages with caffeine? <input type="checkbox"/> never <input type="checkbox"/> less than 1 caffeinated beverage per day <input type="checkbox"/> 1-2 caffeinated beverages per day <input type="checkbox"/> 2-3 caffeinated beverages per day <input type="checkbox"/> 3-4 caffeinated beverages per day <input type="checkbox"/> 4-5 caffeinated beverages per day <input type="checkbox"/> more than 5 caffeinated beverages per day | Hand of Dominance <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> amidextros |
|---|--|

Military Service (branch, rank at discharge, discharge type) _____

Did the patient serve during wartime/ was trauma suffered? _____

HEALTH HISTORY

Please select all choices that apply to the patient.

- | | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> colon cancer | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> peptic ulcer | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> hepatitis A | <input type="checkbox"/> kyphosis | <input type="checkbox"/> PMS | <input type="checkbox"/> stomach cancer |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> juvenile diabetes | <input type="checkbox"/> hepatitis B | <input type="checkbox"/> leg pain | <input type="checkbox"/> Polio | <input type="checkbox"/> stomach ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> adult diabetes | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Profuse Menstrual | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> lordosis | <input type="checkbox"/> prostate cancer | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> hip pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> traumatic arthritis |
| <input type="checkbox"/> Bone Cancer | <input type="checkbox"/> duodenum ulcer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> lower back pain | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> brain cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> hypertension | <input type="checkbox"/> lung cancer | <input type="checkbox"/> rectal cancer | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> hyperthyroidism | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> breast cancer | <input type="checkbox"/> esophageal cancer | <input type="checkbox"/> hypotension | <input type="checkbox"/> migraine | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Bulemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> gouty arthritis | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> |

Select all choices that apply to the patient's family (please do not include relations by marriage).

- | | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> colon cancer | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> peptic ulcer | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> hepatitis A | <input type="checkbox"/> kyphosis | <input type="checkbox"/> PMS | <input type="checkbox"/> stomach cancer |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> juvenile diabetes | <input type="checkbox"/> hepatitis B | <input type="checkbox"/> leg pain | <input type="checkbox"/> Polio | <input type="checkbox"/> stomach ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> adult diabetes | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Profuse Menstrual | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> lordosis | <input type="checkbox"/> prostate cancer | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> hip pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> traumatic arthritis |
| <input type="checkbox"/> Bone Cancer | <input type="checkbox"/> duodenum ulcer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> lower back pain | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> brain cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> hypertension | <input type="checkbox"/> lung cancer | <input type="checkbox"/> rectal cancer | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> hyperthyroidism | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> breast cancer | <input type="checkbox"/> esophageal cancer | <input type="checkbox"/> hypotension | <input type="checkbox"/> migraine | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Bulemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> gouty arthritis | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> |

Patient smokes:

- | | | | | | |
|---|--|---|--------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> 2+ packs per day | <input type="checkbox"/> 2 packs per day | <input type="checkbox"/> ½+ pack per day | <input type="checkbox"/> Never | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> 1 pack per day | <input type="checkbox"/> ½ pack a day or less | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient uses alcohol:

- | | | | | |
|--------------------------------------|-------------------------------------|---------------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Excessively | <input type="checkbox"/> Moderately | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
|--------------------------------------|-------------------------------------|---------------------------------------|---------------------------------|--------------------------------|

Medication the patient is currently taking:

- | | | | | | |
|--|--|--|--|--|--------------------------|
| <input type="checkbox"/> Analgesics | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> No prescription medications | <input type="checkbox"/> Psychotropic medication | <input type="checkbox"/> |
| <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Hypertension | <input type="checkbox"/> No non-prescription medications | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Vitamin supplements | <input type="checkbox"/> |

Allergies - please mark all that apply:

- | | | | | | |
|--|---|--------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Animal Dander | <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Dust | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Pollen | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Latex | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Secondary Smoke | <input type="checkbox"/> No known allergies |

Who is/was your most recent general physician? _____

What was his/her diagnosis? _____

Who was your last Doctor? _____

What were his/her findings? _____

Please list any previous injuries and/or accidents with approximate dates:

Past Surgical History (include date, location, surgeon's name, the type of surgery, and list complications)

Past Hospitalizations (date, complications, and cause of hospitalization)

FEMALES ONLY:

When was your last period? _____

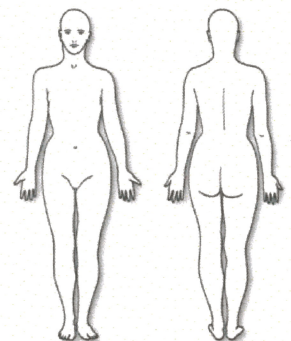
Are you pregnant?

- Yes No Not Sure

FAMILY HISTORY

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

- Mother
 Father
 Brother
 Sister
 Spouse
 Child



Please outline on the diagram the area of your discomfort.

Most patients that come to our office have one or 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.

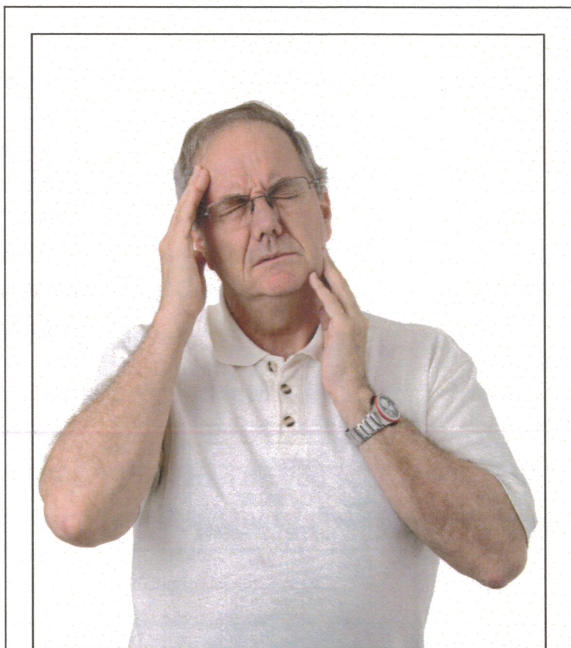
Please check the type of care desired so that we may be guided by your wishes whenever possible

- Relief Care
 Corrective Care
 Check here if you want 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 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. See office policy regarding payment.

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 _____