DATE	I.D. #

CONFIDENTIAL PATIENT HEALTH RECORD

OUTLINE OF YOUR CARE PROCEDURES

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 our 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 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: _____

Birth Date: _____ Age: _____ ☐ M ☐ F City: _____

Home Phone #: _____ State/Prov.: _____ Zip/Postal Code: _____

Cell Phone #: _____ Social Security #: _____

Email Address: _____ Referred to This Office By: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated

Name of Spouse: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Spouse's Business Phone #: _____

Type of Work: _____ Names and Ages of Children: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible for Your Bill, You and: ☐ Spouse ☐ Worker's Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

Name of Insurance Company: _____ Health Card #: _____

Name of Insured: _____ Date of Birth: _____

Name of Other Insurance That May Cover This Condition: _____

CURRENT HEALTH CONDITION(S)

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Circle the number which best represents the severity of your symptom(s): ▼none.....to.....severe▼	Please check the box that best represents the percentage of time you feel pain or symptom(s):
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25 ☐26-50 ☐51-75 ☐76-100
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25 ☐26-50 ☐51-75 ☐76-100
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25 ☐26-50 ☐51-75 ☐76-100
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25 ☐26-50 ☐51-75 ☐76-100

For each of the reasons or conditions listed above, please mark how it happened:

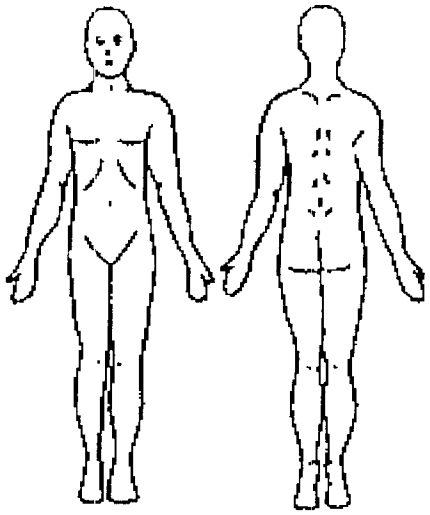
1 ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident Other: _____ ☐ I don't know
2 ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident Other: _____ ☐ I don't know
3 ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident Other: _____ ☐ I don't know
4 ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident Other: _____ ☐ I don't know

For each of the reasons or conditions listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on the line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

Please mark the areas of discomfort or pain on the your figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐

_____

a. During what time of the day do you feel worse? _____
b. Do you sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _____ to _____
c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
☐ No ☐ Yes → For what condition(s): _____
Name of provider being seen for other condition(s): _____ Phone: _____
d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
☐ No ☐ Yes → Please describe below:
Event _____
Event _____
e. Do you exercise? ☐ No ☐ Yes → Please describe activity _____
How many days a week? _____ How many minutes per session? _____

PERSONAL HISTORY

Please check the box next to each condition that applies to you.

Pain in body

- ☐ Neck pain with difficulty swallowing
- ☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain that worsens with exercise but is relieved by resting
- ☐ Loss of feeling in inner thighs
- ☐ Back pain with urinary problems

Types of pain

- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ☐ Unable to balance when walking
- ☐ Recent unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness nausea or faintness when neck is in certain positions
- ☐ Recent major accident such as a fall from height, whiplash or blow to the head

Previously diagnosed condition/ medical history

- ☐ Congenital bone or joint disorder
- ☐ Rheumatoid arthritis
- ☐ Severe degenerative arthritis
- ☐ History of compression fracture
- ☐ History of heart attack
- ☐ History of stroke or aneurysm
- ☐ Past history of cancer or currently diagnosed with cancer
- ☐ Diabetes with cold, burning or numb feet
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression such as from chemotherapy, organ transplant, etc.
- ☐ 3 or more months use of steroid medications or intravenous drugs (past or recent)

FAMILY HISTORY

- ☐ Autoimmune disorders
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Seizure disorder

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).

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

☐ **Relief Care** ☐ **Corrective Care**

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 care, 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 films 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* _____

Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

Witness _____ *Date* _____